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TEXAS STATE JOURNAL OF MEDICINE

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CONTENTS

EDITORIALS	Page
Reorganization Plan Number One Defeated	613
Texas' Response to American Medical Association Assessment	614
Community Chests Deserve Support	615
Current Editorial Comment	
Diabetes Detection Drive	615
ORIGINAL ARTICLES	
Diabetes Mellitus—An Orientation *Cecil Striker*	617
Neglected Diabetic Patients *J. Shirley Sweeney*	623
Diabetes Mellitus and Pregnancy *Oran V. Prejean and Jack B. Griffin*	627
The Doctor in His Relationship to the Community *W. L. Pressly*	630
Preoperative Management of the Jaundiced Patient *Francis J. Kelly*	633
Recent Advances in the Chemical Supportive Therapy of Thermal Injury *Carl A. Moyer*	635
A New Antibacterial in Surgery; Sulfamylon-Streptomycin *W. R. Whitehouse, R. W. Kimbro, and Glenn R. Wright*	639
Diaphragmatic Hernia from a Roentgenologic Viewpoint *B. R. Kirklin*	642

NEWS	Page
Coming Meetings and Clinics	649
Postgraduate Courses of Dallas Southern Clinical Society	650
United Medical Administration; Hoover Commission Report	651
Texas Urological Society	651
Texas Health and Medical Boards	651
San Antonio Tumor Seminar	652
Oklahoma City Clinical Conference	652
Industrial Health Conference	652
Lone Star State Medical Association	653
Texas Pediatric Society	654
LIBRARY SECTION	
Package Service	654
Library Needs	654
Motion Picture Film Library	655
Book Notices	655
ORGANIZATION SECTION	
State Medical Association Health Talks Available to Lay Press	659
County Societies	659
AUXILIARY SECTION	
Legislative Chairman Requests Meeting Dates	661
Annual Reports of County Auxiliaries	661
Auxiliary News	664
DEATHS	665
ADVERTISERS INDEX	67

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REORGANIZATION PLAN NUMBER ONE DEFEATED

With a vote of 60 to 32 the United States Senate on August 16 rejected President Truman's Reorganization Plan Number One through approval of Senate Resolution 147, thus reducing for the time being the threat of a Department of Welfare and a cabinet post for Oscar Ewing. Senate Resolution 147, introduced by Senator Fulbright (D., Ark.), was as follows:

"*Resolved,* That the Senate does not favor the Reorganization Plan Number One transmitted to Congress by the President on June 20, 1949."

The Reorganization Plan would automatically have become law by executive decree in sixty days unless disapproved by either the Senate or the House of Representatives. Hearings were held by the Senate Committee on Expenditures in the Executive Departments, of which Senator McClellan (D., Ark.) is chairman, on the Reorganization Plan and on S. R. 147 and after receiving 30 statements and 1,498 letters and telegrams, 1,404 opposing and 94 supporting the plan, the committee submitted its report opposing the plan in what is known as the McClellan Report (No. 851).

The six major objections given are as follows:

"1. The plan does not conform to the recommendations of the Commission on Organization of the Executive Branch of the Government for the establishment of a Department of Welfare, primarily in that it omits the Commission's recommendation relating to consolidation of all major Federal medical facilities, including the Public Health Service, in a proposed independent United Medical Administration.*

"2. The functions of health, and education to a lesser extent, have been 'dominated' by and 'subordinated' to the function of welfare by the Federal Security Agency, to the detriment of the former. The power which accompanies departmental status and the increased prestige which the Secretary of Welfare would gain would augment this existing trend toward subordination of education and health to welfare.

"3. Further, the plan, by virtue of section 2 (b), (c) which vests in the Secretary of Welfare authority to consolidate and to delegate functions, with minor reservations, destroys any degree of independence, or autonomy, the Public Health Service and the Office of Education presently enjoy. The

*EDITOR'S NOTE: *A summary of the recommendation of the Hoover Commission on a United Medical Administration will be found on page 651 of this issue.*

plan actually gives the Secretary of Welfare complete control over all functions of the Department, authorizing him to reorganize them, within statutory limitations, in such manner as to give the Secretary outright domination over the Administration of the health, education, and welfare activities of the Government.

"4. The health of the people by any criterion is of such importance as to merit separate Cabinet recognition, or an independent administrative status. Continuation of the Federal Security Agency's policies relative to health, or extension of those policies through a Department of Welfare, would be detrimental to the best interests of the Nation's health....

"5. Elevation of the" Federal Security Administration to a Department "is a step forward toward socialized medicine." Cabinet status would increase the influence of the Federal Security Administrator and advance his programs for national compulsory health insurance.

"6. No economies can be expected to be achieved in the immediate future from conversion of Federal Security Agency to a Department of Welfare."

The Senators who spearheaded the fight in favor of S. R. 147 were Senators Fulbright (D., Ark.), Taft (R., Ohio), Hunt (D., Wyo.), McCarthy (R., Wis.), Donnell (R., Mo.), and Malone (R., Nev.). These in addition to Senator McClellan were the ones who carried the ball in opposition to Reorganization Plan Number One.

As mentioned earlier, the immediate threat of a Department of Welfare such as is advocated by President Truman has been lessened, but this by no means indicates that such a threat is passed. Already there has been introduced an amendment to S. 2060 which would set up a Department of Health, Education, and Security intended to be more in keeping with the Hoover Commission recommendations than is the President's Reorganization Plan Number One, but this is still a long way from the hope of the medical profession as expressed in the first point of the American Medical Association Twelve Point Program, that of a Department of Health with a doctor of medicine holding cabinet status at the head.

The doctors of Texas should be on the alert and study carefully every bill introduced in Congress which bears on this subject. As time goes on the editors of this JOURNAL will endeavor to point out to its readers the developments in this and other legislative matters of importance to the medical profession.

TEXAS' RESPONSE TO AMERICAN MEDICAL ASSOCIATION ASSESSMENT

The response of the membership of the State Medical Association of Texas to the $25 assessment placed on all members of the American Medical Association at the interim session of the Association at St. Louis in December, 1948, has not been up to expectations. Although there has been no effort on the part of the A.M.A. to make the assessment compulsory in any manner, the realization of the purpose of and need for the funds such an assessment will provide has been sufficiently understood and appreciated that the response from the country as a whole has been much better than from our own state despite the fact that a number of county medical societies of this Association have good records of participation; a few of these have been 100 per cent.

A recent communication from the Secretary of the American Medical Association indicates that Texas is forty-fourth among the fifty-three constituent associations in the percentage of its members who have paid the assessment. Letters have gone forward to each member of this Association pointing out these facts and urging all who have not already done so to mail in their $25 checks at once. These may be sent through the county medical society secretaries to the State Association office, or direct to the A.M.A. office, the former being preferable.

The need for additional funds by the A.M.A. to carry on its regular scientific program and to intensify its public relations and public education programs has repeatedly been brought to the attention of the membership of this Association through the pages of this JOURNAL and through other medical literature. As a re-

sult of this need, the House of Delegates of the A.M.A., for the first time in its one hundred year history, voted to assess the members of the Association.

Since that time the American Medical Association with the cooperation and assistance of the constituent associations has been carrying on an intensive program which is known as the National Education Campaign. Some of the literature which has been produced as a result of this campaign has been placed in the hands of each member of this Association, the effectiveness of which the membership has had an opportunity to see.

Texas doctors have always had the reputation of doing their part in any project demonstrated to be in the interest of better medical service. They can surely be depended upon to come forward at this time and place Texas in its rightful place among the leaders instead of trailing toward the end of the line.

COMMUNITY CHESTS DESERVE SUPPORT

The red feather, once an Indian symbol of achievement, today signifies achievement for each person who participates in a Community Chest campaign. It symbolizes defeat of a community enemy, which may be disease, delinquency, neglect, or injustice.

No one knows better than physicians the need for Community Chest funds. They see Community Chest money at work on a local level everywhere—in aid to the handicapped, children's aid, clinics, day nurseries, family service, homes for the aged, hospitals, maternity homes, and visiting nurses' associations, to name only a few agencies which have benefited. National organizations, too, are helped: the Salvation Army, Boy Scouts, Girl Scouts, YMCA, and YWCA, among others. All in all, about 12,000 voluntary Red Feather services exist.

This year it is obvious that a large amount of money will be necessary for the Community Chest to carry on its aid to such a great number of worth-while organizations. By one united appeal the Chest eliminates duplication of effort and costs of conflicting campaigns and assures the effective use of and accounting of funds. What the once-a-year appeal means, however, is that pledges to be paid throughout the year may be necessary in place of the one donation considered as adequate by some contributors.

No national fund is raised, but local Community Chests, united in the "Community Chests of America," coordinate their publicity and promotional efforts in making October Community Chest month. The familiar Red Feather symbol prevails for a month, but the good it does lasts throughout the year. The Community Chest is an integral part of our present-day American society. Texas physicians will surely do their part to make the Community Chest drives a success.

CURRENT EDITORIAL COMMENT

DIABETES DETECTION DRIVE

The American Diabetes Association, with the approval of the American Medical Association, has scheduled a year-round Diabetes Detection Drive beginning with Diabetes Week, October 10-16, 1949. The purpose of this drive is to discover and bring under treatment the estimated one million unknown persons with diabetes in this country. The success of the undertaking depends largely upon the cooperation of the entire medical profession. With this idea in mind the American Diabetes Association has sent questionnaires to medical societies

This department of the JOURNAL *presents editorial comments on current items pertaining to the science, art, and practice of medicine, contributed by members of the State Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the State Medical Association of Texas to submit such discussions for this department. The discussions should not be more than 500 words in length.*

throughout the nation and is making informational material available to these societies. It is urged that the first step in the campaign be the establishment of committees on diabetes for the planning of the local programs. The drive itself will require proper publicity through press and radio, talks on diabetes before various nonmedical organizations, and the setting up of detection centers for the free testing of urine. In addition, it is planned to have kits for the self-testing of urine on sale at nominal cost in drug stores. Positive urine tests for sugar by detection centers or by self-testing are to be reported to the patient's family physician.

In Texas there are now two active diabetes associations, the Dallas Diabetes Association and the Texas Diabetes Association, organizations entirely independent of each other but having the same general purpose, namely, the spread of information about diabetes and the encouragement of research on various aspects of the disease.

The Dallas Diabetes Association consists of a Clinical Society with membership open to members of the Dallas County Medical Society and a Lay Society, now in the process of organization. The Clinical Society is a recognized affiliate of the American Diabetes Association. As a result of the efforts of the Dallas Diabetes Association, the United States Public Health Service has sent one of its four detection and demonstration units to Dallas in preparation for a full scale detection drive to begin in October.

The Texas Diabetes Association consists at present of a Clinical Society with membership open to any member of the State Medical Association of Texas. Application has been made for affiliation with the American Diabetes Association. The Clinical Society will hold its next annual meeting in Fort Worth on Sunday, April 30, 1950, immediately before the annual session of the State Medical Association. The organization of a Lay Society is planned for the near future.

At present there is not a single camp for diabetic children in the entire South. It is hoped that the first such camp can be in operation this coming spring near Gainesville, Texas. It is to be a nonprofit organization sponsored by the Sweeney Diabetic Foundation.

With proper cooperation between the American Diabetes Association and the diabetes associations and medical societies of Texas, this drive cannot fail to accomplish much good in the interest of public relations and public health in this state. Let us all work together to make the Diabetes Detection Drive an outstanding success!

W. N. POWELL, M. D., Secretary,
Texas Diabetes Association,
Temple, Texas.

Scott and White Clinic.

STUDENTS TO GET MEDICAL HISTORY JOURNALS

The widow of the founder of the *Journal of the History of Medicine and Allied Sciences,* Mrs. Josiah C. Trent, Durham, N. C., has instituted an annual gift of 250 one-year subscriptions of that publication to be allocated to the medical schools in the United States and Canada. Recipients will be selected by the faculty from among those in the yearly graduating class who have shown an interest in the cultural aspects of medicine.

BREAST CANCER MOVIES TO BE MADE

A grant to the American Cancer Society by the National Cancer Institute will be used to produce a movie to show women the basic facts about breast cancer. The movie will include a simple technique for periodic self-inspection of the breasts and is intended for women's clubs and organizations. An animated color film designed for small projectors, it will run for ten minutes and is part of a public information campaign that will include pamphlets and other explanatory materials.

The grant also covers the federal cost of completing a thirty-minute film depicting techniques of breast cancer diagnosis directed toward physicians and medical students. Completion of the film is expected this fall.

Breast cancer mortality, now about 17,000 a year, could be cut in half, believes Dr. Austin V. Deibert, Chief of the National Cancer Institute Control Branch, if women were alert to the early signs and symptoms and sought prompt medical attention.

The proportion of deaths from tuberculosis among people over 45 years of age is steadily increasing.—Robert J. Anderson, M. D., Pub. Health Rep., April 1, 1949.

ORIGINAL ARTICLES

DIABETES MELLITUS—AN ORIENTATION

CECIL STRIKER, M.D., F.A.C.P., Cincinnati, Ohio

ON November 14, 1921, at 4 o'clock in Physiological Journal Club Room 17 at the University of Toronto, Dr. Banting and Mr. Best presented a report entitled "Pancreatic Diabetes." The first two papers reporting the results of their work were published in February, 1922, and May, 1922, in the *Journal of Laboratory and Clinical Medicine*, vol. 7. The official titles were "The Internal Secretions of the Pancreas," page 251, and "Pancreatic Extracts," page 464. Since these original publications, there have been more than 30,000 articles written concerning the experimental and clinical uses of insulin, in addition to which there has been an unfolding of a new experimental era in carbohydrate metabolism.

It is not necessary to list many of the dramatic changes that have taken place since the discovery of insulin. Too many physicians can recall the pathetic state of the juvenile diabetic patient in the pre-insulin era, when life expectancy was at a maximum of from 2 to 3 years. Then, too, who has forgotten the complete invalidism of diabetic adults who were kept alive "to die from starvation." Diabetic coma almost invariably meant death, and surgery in the diabetic patient was a battle between the surgeon and the internist. Today we see juveniles with diabetes growing into adulthood as "normal" citizens accepting all of the responsibilities thrust upon them. Pregnancy in the diabetic woman no longer is prohibited. Life expectancy of the person with diabetes now approaches 70 years, only slightly short of normal expectancy. Diabetic patients are now candidates for insurance, which heretofore has been denied them.

All of these are tremendous advances of comparatively rapid speed, but greater challenges are before us. The degenerative processes which are disproportionately high in the middle aged and elderly diabetic patient force us to concentrate our researches on the all too common complications, such as retinopathy, coronary disease, renal complication, and peripheral vascular disturbances. It may be that these are not the complications but the concomitants of diabetes, that is, in persons who have diabetes there may be a more fundamental disturbance and diabetes may be only a single expression of a more fundamental disturbance.

Read before a general meeting, State Medical Association of Texas, Annual Session, San Antonio, May 3, 1949.

Vital statistics show that between 30,000 and 35,000 persons die annually in the United States of diabetes. A recent intensive survey in New England showed that in a small homogeneous population, for every 3 known diabetic patients in this area 1 person not previously known to have the disorder was found. Further, vital statistics show that diabetes has gone from twenty-second to eighth as a cause of death in the United States. These data indicate that diabetes is now a public health problem and that intensive public health programs are necessary to track down the unknown diabetic sufferer.

DIABETES ASSOCIATIONS

This responsibility is being assumed by the American Diabetes Association, and ways and means are being devised for the entire medical profession to engage actively in a nationwide detection campaign. In the not too distant future an effective program will be sent to every physician in the United States with recommendation that a complete urinalysis be done routinely and suggestions of methods for mass blood sugar determinations. These blood sugar determinations will be accomplished by a simple laboratory procedure which can be done almost as easily as the mass roentgen-ray program is carried out. The Diabetes Office of the United States Public Health Service has joined with the American Diabetes Association to undertake more intensive surveys to find the unknown persons with diabetes. This Office has made intensive surveys at Oxford and Brookline, Mass., and is now undertaking another in Jacksonville, Fla. Thus for the first time accurate data will be established and more complete knowledge will be obtained about the prevalence of diabetes.

There are in the United States many local diabetes associations actively engaged in the study of numerous aspects of the disease. Many of these local associations have separate divisions for scientific discussion and for lay meetings. These lay meetings are important, as the patient himself can learn and participate in discussions about his illnesses. In Cincinnati, our professional division, organized since 1935, meets monthly for discussion. The other division, named "The Cincinnati Diabetics' Association" and with a membership of more than 450, meets quarterly, has its own internal organization, and prepares its

own programs. Similar organizations are established in New York, Philadelphia, Cleveland, and other areas. There are in fact or in organization 54 local groups in the United States. All of these are able to receive the advice and help of the American Diabetes Association.

The Association publishes its *Proceedings* and *Diabetes Abstracts,* which are of invaluable assistance to members of the Association in keeping current with the literature. A manual for the treatment of diabetes is being prepared for use by physicians. This manual will outline the minimum requirements for the handling of the diabetic patient and it is to be hoped that no patient will receive less treatment than is outlined in this handbook. The American Diabetes Association has also assumed the responsibility for publication of a magazine for the lay diabetic patient—*ADA Forecast*—the object of which is to give the person with diabetes accurate, complete, and understandable information about his condition.

In addition, the Association has developed an insulin syringe, which for the first time will make it possible to prevent errors by diabetic patients in dosage of insulin. This is exceedingly important as many serious accidents have been recorded as the result of misunderstanding in the use of syringes, and the diabetic patient who travels will no longer be faced with a strange type syringe after an accident to the syringe that he has been accustomed to. These syringes will be made by the reputable syringe manufacturers and will be available shortly as the official A.D.A. insulin syringe.

Thus it is plain that the American Diabetes Association has assumed the responsibility of protection of and the dissemination of knowledge for the diabetic patient as well as scientific information for the medical profession.

PROBLEMS IN HANDLING DIABETES

What are some of the problems that confront us in handling the patient with diabetes? The more important ones relate to the type of diet, significance of blood sugar, types of insulin, complications (retinopathy, gangrene), ketosis, hypoglycemia, and psychologic factors.

Diet

In the pre-insulin era, it was imperative that all diabetic patients be placed on a submaintenance diet. It was the choice between life and death, life being defined as a state of chronic malnutrition with almost total disability. Subsequent to the discovery of insulin, diets were rapidly expanded, yet for a long period, and even now in some instances, rigid dietary programs were prescribed with complete subservience to the scale. Not a few patients are advised to weigh every morsel of food ingested. Those who adhere to this system fail to realize that with insulin an adequate diet may be used. I believe that no diet which will keep a patient in chronic malnutrition should be prescribed because I am sure that many of the complications ascribed to diabetes in the pre-insulin era were the result of chronic undernutrition and malnutrition. Many of the complications that went with the pre-insulin era were duplicated recently in the thousands of war victims who suffered and died from starvation. As a basic concept, every physician should prescribe an adequate diet for his diabetes patient and if he cannot be controlled on this alone, insulin is indicated.

There are two broad schools of thought today in reference to the diabetic diet. These are exemplified by the Joslin group, who advocate a limitation of food intake, and the Tolstoi group, who advocate a freer type of food intake. No physician believes that his patient adheres rigidly to a restricted type of diet, and even in the more liberal type of diet many patients eat more than is prescribed. I advise my patients to follow a constant type of food intake averaging between 250 and 300 Gm. of carbohydrates in terms of household measurements. This allows for variety. At the same time I prefer to regulate the total caloric intake. The twenty-four hour output of glucose is measured on this type of diet and a sufficient amount of insulin is given to prevent the active symptoms of diabetes. These symptoms consist of acetonuria, polyuria, polydipsia, and polyphagia. If the patients are overweight, I prefer to have them lose weight.

Blood Sugar

I am not convinced that the level of blood sugar is an important aspect of the control of diabetes. There is no clear-cut experimental evidence nor clinical evidence to indicate that if the patient is well nourished, the level of the blood sugar is conducive either to diabetic accidents or to complications. It must also be recognized that the interpretation of the blood sugar level is exceedingly difficult. When a physician interprets a blood sugar test, he should know the method used in determining the blood sugar, whether it is venous or capillary blood, the time of day when the sample was taken, the type of diet the patient was on prior to taking the blood sugar sample, and the time and dose of insulin. It is an all too common experience in comparing blood sugars taken in different laboratories to find that the differences in blood sugar readings can be accounted for by the circumstances under which they were taken. Evidence has been adduced to show that in a controlled group of diabetes patients with hyperglycemia

subjected to surgery, wound healing has not been retarded and curiously enough it may have been expedited. Further, evidence indicates that in spite of rigid control of the diabetes, particularly in the juvenile patient, in a series of more than 30 patients[10] the incidence of complications were well above 90 per cent. (This group included juvenile patients with diabetes of fifteen years or longer standing.) Therefore, it seems that it may not be the severity of the diabetes nor the control of the diabetes, but the length of time the patient has had diabetes that is the factor in the production of the complication. I might suggest that particularly in the elderly diabetic patient, it is important not to try to bring the blood sugar down to the accepted norm, as in many instances severe hypoglycemic reactions will occur. Further, it is important in interpreting the blood sugar level to take into account the question of renal tubular reabsorption. Too frequently we accept hyperglycemia as a function of carbohydrate regulation, whereas it actually is a function of renal deviation.

Insulin

It is estimated that from 50 to 60 per cent of all patients with diabetes can be controlled without insulin. Of the remaining group, between 10 and 15 per cent are extremely labile and difficult to control, requiring varying doses of insulin. The majority of insulin cases can be controlled by single daily injections of protamine zinc insulin, but those which are either extremely labile or severe may require a maintenance dose of protamine zinc insulin with supplemental injections of quick acting insulin or insulin combinations. The ideal insulin will act long enough to provide some overlapping from day to day and will provide for the metabolism of the daily diet plus prevention of nocturnal insulin insufficiency. Protamine zinc insulin may take care of the nocturnal phase, but in severe diabetes it alone will not take care of the daily metabolic needs.

A "tailor-made" insulin can be prepared taking advantage of the fact that protamine zinc insulin contains an excess amount of protamine; if twice the amount of quick acting insulin is mixed with protamine zinc insulin, the quick acting effect as well as the prolonged effect can be obtained from a single injection. The difficulty involved in preparing this "tailor-made" insulin frequently outweighs the advantages obtained from it; errors of technique and not infrequently contamination of insulin vials occur in the preparation. More recently, a stable, premixed, two to one mixture has been developed by the Lilly Company. This product is now being tested and may be the most acceptable type of insulin, giving a quick acting and a long acting effect with a single injection. It is possible to make many insulin mixtures, but it would be ill advised to place these on the market for further confusion of diabetic patients. There are now three kinds of insulin available, U 40 and U 80 quick acting or regular insulin, protamine zinc insulin, and globin insulin.

Degenerative Disturbances

The degenerative disturbances associated with diabetes frequently become the dominant problem in the care of the patient with diabetes. Retinopathy, intercapillary glomerular sclerosis, coronary artery disease, and gangrene are the more important entities associated with diabetes of long standing. There is considerable controversy going on concerning the role of hyperglycemia in the causation of these conditions. The evidence, both clinical and experimental, does not indicate that there is a cause and effect relationship between these complications and hyperglycemia.

In the juvenile diabetic patients in White's series[10] of 200 patients, 92 per cent showed vascular disturbances after having had diabetes fifteen years or longer, and more recently Lester J. Palmer[5] reported a group of patients having had diabetes twenty years or longer who showed a high incidence of vascular diseases. He stated, "viewed from a clinical standpoint, it is evident that an unknown factor is concerned in the vascular condition of diabetic individuals, and good control alone, although extremely important, is not the sole factor concerned." In the adult diabetic patient it is not uncommon to see an inverse ratio between the severity of the retinopathy and the diabetes. Further, no known form of therapy stems the onward march of the retinal changes. All of us have seen patients go to total blindness without being able to do anything about this condition. Experience has indicated that rutin is of insignificant value in the treatment of these retinal changes.

Peripheral vascular lesions present a difficult problem and each case must be evaluated as to whether conservative or radical measures are indicated. Since the advent of the antibiotics, conservative measures frequently will save a leg in contrast to the hopeless situation of years ago. There are many ways of evaluating the vascular efficiency of the lower extremity, but the most useful are the temperature of the extremity, the quality of the pulsation, and the oscillometric reading. A simple clinical classification has been suggested by Williams and O'Kane[12]: (1) arterial insufficiency (due to sclerosis), (2) infection in a diabetic, and (3) a combination of the two.

Conservative therapy is indicated regardless of the severity of the diabetes when an infection in the lower extremity is present but where there is good vascular supply. In the presence of an infection with severe arterial damage, it is advisable to treat the

patient vigorously with antibiotics before any radical surgery is performed. In my experience the use of ether intravenously and ascorbic acid-histidine therapy has been of little value. I have seen not a few patients admitted with an overwhelming toxemia from absorption from a gangrenous area who were greatly improved by packing the leg in ice for several days before any other procedure was undertaken. It is a dramatic experience to see a drop in the white blood cell count and temperature after this procedure.

At this point, I would like to record the history of a patient 58 years of age who three weeks ago had his second midthigh amputation as a result of severe arteriosclerotic changes, the first amputation occurring three years ago. Inventory of his general condition reveals no electrocardiographic changes and repeated eye examinations by a reputable oculist show no retinal damage. It is difficult to explain the localization of arteriosclerotic processes.

Ketosis

Unlike retinopathy, arteriosclerosis, and other degenerative changes occurring in diabetes, ketosis is a real complication. It is possible to reproduce and relieve this serious complication of diabetes by regulation of insulin usage. Diabetic acidosis is a serious medical emergency which requires immediate and energetic treatment, and that treatment is directed against a disturbance in electrolyte balance and fluid balance. As a rule there are only a few things that will precipitate diabetic acidosis: discontinuance of insulin, infection, surgical operation, injury, pregnancy, and emotional stress. Fortunately, when acidosis occurs, it is ushered in with prominent symptoms such as nausea, vomiting, shortness of breath, epigastric distress, polyuria, and dehydration. Every person with diabetes should be instructed that anything which interferes with his normal routine makes him susceptible to this serious complication.

Irrespective of whether the physician adheres to the minimal or maximal glycosuria viewpoint in the handling of diabetes, it is imperative that no patient be allowed to have a persistent ketonuria, and when this occurs, further adjustment of his insulin must be made. Persistent ketonuria is potentially hazardous and an indication for more vigorous regulation of the diabetic patient. It is important to remember that every patient who has diabetic acidosis is suffering from an acute insulin insufficiency and every therapeutic step should be directed toward the alleviation of this condition. There are many programs outlined for the treatment of the ketotic patient. In my judgment large doses of insulin given at frequent intervals with sufficient amounts of fluid to relieve the severe dehydration is the most acceptable procedure. I prescribe 100 units of quick acting insulin hourly and 2,000 cc. of 5 per cent glucose in normal salt solution on admission and, depending on the degree of dehydration, additional solution at from three to six hour intervals. This therapy is continued until the patient is well hydrated and there are no acetone bodies in the urine.

I would like to stress that the ketotic patient is suffering from a severe dehydration and disturbance in his electrolyte balance and not from hyperglycemia. I have seen patients in severe acidosis with a blood sugar as low as 250 mg. and as high as 1,600 mg. Further, I have seen patients relieved of their ketosis with as little as 200 units of insulin and as much as 2,400 units of insulin. As quickly as possible these patients should be allowed to take liquids orally and within twenty-four hours they should be able to eat soft diet. I cannot stress the importance of the need for frequent observation of these patients as they are one of the most important medical emergencies.

Occasionally, the physician encounters a patient who chemically is satisfactorily controlled, but still remains stuporous or has respiratory difficulty and may even die. It is important to be alert when this condition develops as it may be frequently associated with a disturbance in potassium metabolism. The reduction in the serum potassium concentration may be due to loss of potassium by diuresis and dehydration with resultant loss of intracellular stores of water and potassium, loss of potassium as a result of the effect of insulin, and the reduction of serum concentration due to dilution by parenteral fluid with no outside source of potassium. This condition may be alleviated by the oral administration of 2 Gm. of potassium citrate and, if this is not possible, by an intravenous injection of 2 Gm. of 2 per cent potassium chloride given slowly over a period of from twenty to thirty minutes.

Hypoglycemia

The occurrence of hypoglycemic reactions is infinitely more common than bouts of ketosis in the life history of a diabetic patient. These reactions may range from mild symptoms to acute medical emergencies requiring vigorous treatment. It is not uncommon for patients to have symptoms of hypoglycemia ranging from headaches, perspiration, diplopia, and poor coordination to the more serious disturbances of disorientation, convulsive seizures, and stupor. The occurrence of these reactions is almost always associated with over-dosage of insulin, irregularity in eating, and/or physical activity. Every patient should be advised about the seriousness and the need for immediate relief of the symptoms resulting from lowered blood sugars. Particularly since the advent of protamine zinc insulin with the carry-over

effect, all of us have seen patients with severe early morning reactions; in view of this, all of my patients are advised to take a small amount of food before retiring.

The severity of an insulin reaction is by no means commensurate with the level of the blood sugar. I have had, for example, a patient, sitting up in bed shaving himself with a straight razor, totally asymptomatic, with a blood sugar of 22 mg. In contrast to this, I have had a patient with typical hypoglycemic symptoms dramatically relieved by 50 cc. of a 25 per cent glucose solution given intravenously with a blood sugar of 425 mg. It should be remembered that it is not only the level of the blood sugar that produces the symptoms, but it is the speed of drop of the blood sugar. Not infrequently a physician sees patients with blood sugars over 200 mg. having typical symptoms of hypoglycemia relieved after getting food. Their blood sugar level ranges between 250 and 300 mg. This is particularly seen in elderly persons.

It is important to stress the points mentioned in the preceding paragraph because frequently a physician may treat the blood sugar as the sole index of optimal therapy and forget the clinical condition of the patient. Many patients are referred to me because in the course of a complete physical examination the only abnormal finding has been an elevated blood sugar. These patients have been placed on a restricted diet and in some instances have been given insulin. From that point on they have manifested severe symptoms of hypoglycemia and have been confronted with a whole train of symptoms induced by a misinterpretation of the blood sugar level. This group is easily treated by the simple expediency of enlarging their diet and stopping their insulin. They do not have diabetes as repeated glucose tolerance curves are normal and they only present the symptom of a high renal threshold.

Not infrequently the physician is confronted with an unconscious patient having a history of diabetes, and the differential diagnosis between hypoglycemia and diabetic coma (ketosis) must be made. This is not too difficult because it should be remembered that almost invariably all the symptoms of hypoglycemia come on fairly rapidly with the patient giving a history of having felt fine prior to the presenting symptoms. In contrast to this, the patient in diabetic coma invariably has a history of indisposition for many hours or one or two days prior to the onset of the coma. In addition to this, the acidotic patient invariably is dehydrated, is nauseated and vomiting, is hyperpneic, and is severely toxic, whereas in the hypoglycemic coma the patient is hydrated and usually has slow, shallow respiration. The physician should always be on the alert when making this differential diagnosis as I have seen patients in hypoglycemic coma given extra amounts of insulin in the confusion of the emergency. The dramatic recovery of hypoglycemic coma patients by the intravenous use of concentrated glucose is well known.

I cannot emphasize too strongly hypoglycemia as an important complication in the treatment of persons with diabetes. I am thinking of a prominent surgeon in Cincinnati who had a severe case of diabetes. As a result of an insulin reaction while driving he crashed into another automobile, was immediately taken to the police station and placed in a cell, and a charge of drunkenness was placed against him. I was called to see him and by simple therapeutic agents relieved his hypoglycemia, whereupon he was immediately dismissed. It is not uncommon for anyone seeing a fairly large group of diabetic patients to have similar experiences.

Pregnancy

With the dramatic lengthening of life of the juvenile with diabetes there is a large population of potentially childbearing diabetic women who are concerned about many problems associated with pregnancy. Most diabetic women can become pregnant; while the hazard to the mother is practically nil, there is still a high mortality to the offspring. There are two schools of thought in reference to the hormonal imbalance in the pregnancies of diabetic women. One school, headed by Priscilla White, believes that every pregnant diabetic woman should receive routine sex endocrine therapy. This consists of intramuscular injections of stilbestrol and Proluton. They state that "in the past two or three years early and aggressive treatment has coincided with the disappearance of abortion and miscarriage."[9] On the other hand, there are equally valid data that under ample supervision without hormonal therapy equally good results are obtainable. In the last 20 pregnancies under my supervision, I have had a mortality of 2 babies and none of these patients has had any hormonal therapy. I believe that all primipara should have a cesarean section three weeks before term. It is important to know that frequently after delivery there may be a rather dramatic remission in the severity of the diabetes, which may persist for from three to seven days. In one instance a severe hypoglycemic reaction occurred as this fact was not taken into consideration.

Diabetes in the newborn infant does not exist, yet I can report the occurrence of diabetes in a 9 day old baby from a nondiabetic mother, but with one of the other two children in the family having diabetes. This case is under the supervision of Dr. George M. Guest of the Children's Hospital in Cincinnati. The baby is now 2½ years old.

EXPERIMENTAL PROBLEMS

What does the future hold for us who are treating diabetes and what does it hold for the diabetic patients themselves? In the experimental area many interesting problems are being investigated. I will enumerate only a few: alloxan diabetes, isotopes, insulinase, experimental arteriosclerosis, action of insulin, and the Houssay dog (pituitary diabetes).

Alloxan is a substance related structurally to uric acids, which when injected into animals destroy the beta cells of the islets of Langerhans in the pancreas and produces diabetes. Thus for the first time a method has been obtained to illustrate a specific effect on the insulin producing gland of the body. This chemical, and a search for other chemicals, opens up a new avenue of approach to the etiology of diabetes, and although it may not demonstrate the specific factors involved, it at least will allow for other clinical investigations. This is important because most of the thinking about the etiology of diabetes has been along hormonal activity.

More recently, Stetten and Chaikoff have used tagged carbon atoms in the study of carbohydrate metabolism. These and other workers are trying to find out at what point in the glucose-to-energy framework insulin acts. It is apparent that now we must not think of diabetes in terms of glucose metabolism, but must think of it in terms of hexokinase reaction, phosphorylation, transamination, and many other new terms. It is important to have a fairly clear concept of the work of Cori and Cori, who demonstrated this in vitro production of glycogen from glucose. With the work of Houssay, Young and Soskin, and others it is clear that the idea that diabetes is more than a disease of the pancreas is now well established. The evidence is clear that other glands such as the pituitary, adrenal cortex, and thyroid play a definite role in homeostatic mechanism. Further, the role of the liver in the regulation of carbohydrate metabolism is clearly established, and now by further experimental evidence it is apparent that tissue enzyme chemistry will reveal important fundamental processes in the understanding of diabetes. Recently Mirsky has demonstrated an anti-insulin substance, which may be a factor in the etiology of diabetes. He has demonstrated the presence of insulin in the urine in diabetic patients, indicating that there is no insulin insufficiency, but also has demonstrated the marked increase in experimental diabetic animals of the anti-insulin substance, which may be responsible for the disturbance in carbohydrate metabolism. If this can be confirmed, it will be a fundamental contribution to the field of diabetes.

There was a time when life was simple. We thought in terms of molecules and atoms, but now in the atomic age, everything moves in incomprehensible speed. So it was with diabetes. Many of us can look back to the time when we thought of the diabetic patient in terms of the amount of sugar he had in his urine. Today, this is not possible. We are clinicians and our prime responsibility is to our patient, and yet the unraveling of the problems of this single disease offers an exciting experience.

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Jewish Hospital.

INDEPENDENT PHYSICIANS EARN MORE

Independent physicians net 43 per cent more income than do doctors on salary, according to a nationwide survey conducted by *Medical Economics* and reported in the May issue.

Average net income received in 1947 by independent practitioners was $11,300; by their salaried colleagues, $7,914.

"More than half the salaried men have been in practice less than ten years, as against 37 per cent of independent physicians," the survey reveals. Ten per cent of all active, private physicians receive more than half of their income from salaries.

VETERANS IN MEDICAL SCIENCE

More than 83,000 World War II veterans are studying medicine and related subjects in school and colleges under the G. I. Bill and Public Law 16 (for the disabled).

A Veterans Administration survey in December, 1948, among 2,535,385 veterans enrolled in schools and job training establishments under both laws revealed that veteran-students in the medical sciences represented 3 per cent of the total number of all trainees. Of the 78,143 veterans enrolled under the G. I. Bill, more than one-third, or 23,260, were taking courses in medicine and surgery.

NEGLECTED DIABETIC PATIENTS

J. SHIRLEY SWEENEY, M.D., Sc.D., F.A.C.P.,*
Gainesville, Texas

IT is the purpose of this presentation to draw attention to a number of things that should be included in the over-all evaluation of any diabetic patient and his management. The average practitioner, perhaps too often the average internist and pediatrician, is not especially interested in diabetes mellitus nor in its management. Too often many simple and obvious factors that are of real value in the proper management of the patient with diabetes are never discussed or never explained. Unless we doctors give each diabetic patient a thorough, *individual* understanding of his problems we are derelict in our duties.

While the fundamental mechanics of diabetes have changed but little in the last decade or so, many new and interesting appendices have been added from researches in sugar metabolism. Thus our unsolved problems are more apparent and better crystallized.

There are three groups which I shall consider: (1) the potential diabetic, (2) the unsuspected diabetic, and (3) the known diabetic patient.

POTENTIAL DIABETIC PATIENT

By the potential diabetic patient is meant that person who has in his family background known cases of diabetes. This refers not only to his progenitors but to his immediate parents and siblings. If such a person is encountered in routine practice, and this statement presumes that a careful history is taken on all patients, he should be told something about the hereditary aspects of diabetes. Joslin[5] stated that "heredity is the basis of diabetes." In fact, in the etiology of diabetes heredity is practically the entire explanation. While there may appear to be precipitating causes such as endocrine shifts of one sort or another, especially at the adolescent and involutional periods of life, the hereditary basis still remains the most important factor in the cause of diabetes. One of the strongest bits of evidence regarding heredity of diabetes is the almost simultaneous occurrence in pairs of similar twins. Approximately 50 per cent of these had the disease as compared to 3.2 per cent of dissimilar twins who had the disease.[7]

It is variously estimated that from 35 to 50 per cent of patients with diabetes give a positive diabetic background. It is believed by many that these figures should in reality be higher insofar as diabetes often escapes diagnosis, particularly in the older person. It is therefore encumbent upon all of us to ask something about the background of every patient we see. It is believed that if this simple thing were done detection of potential diabetics would be much easier and much more common.

Theoretically, pancreatitis, acute, subacute, or chronic, would be thought of as the most likely etiologic factor in diabetes. Actually, this is not true. Many cases of acute, subacute, and chronic pancreatitis are observed without any alterations whatsoever in the blood sugars. At the same time there have been some cases observed in which there was some alteration. Again it would seem to be on a hereditary basis. This point was illustrated in a short paper entitled "Pancreatitis and Diabetes Mellitus" which I published in 1931 in the *Journal of Endocrinology*.[6] It referred to a patient who developed pancreatitis with its characteristic pathologic manifestations. There appeared a definite diabetes with jaundice which disappeared after a cholecysto-jejunostomy was performed. In this patient, however, there was a heavy background of diabetes. His father and mother both had died with diabetes; likewise, one brother. It is interesting that after the load was removed from the pancreas by the surgical procedure the patient was able to keep his diabetes under control without insulin and ostensibly had no diabetes as long as his diet was properly handled. However, consumption of too many carbohydrates invariably tipped him over to a diabetic state. There have been other cases of pancreatitis and diabetes reported, but only less than a dozen cases, while there are reports of a large number of cases of pancreatitis without diabetes.

If heredity is the basis of diabetes, every person who gives a history of having diabetes in the family should be cautioned regarding possible development of diabetes. The suggestion should be made to such a patient that he have his urine checked from time to time for sugar and if there is any doubt to have a blood sugar test made approximately one and one-half hours after an average breakfast.

Next to heredity is obesity as an important factor in the precipitation of the diabetic state. Obesity is in a large measure hereditary; nevertheless, since laymen do not understand this relationship, we may consider the two factors independently. Every obese patient should be questioned regarding diabetes. Every obese person should have his urine checked for sugar. If there is a hereditary background of diabetes, every obese person should be made to reduce; regardless

*Medical Director, The Sweeney Diabetic Foundation, For the Study and Treatment of Diabetes and Allied Metabolic Disorders.
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of a diabetic background, it is advisable to have every obese person reduce his weight to "normal." I agree with Gastineau and Rynearson[3] that "obesity is one of the most pressing and dangerous health problems we face today." Fortunately we *can* do something about obesity, although unfortunately we cannot change the manifestations of heredity.

UNSUSPECTED DIABETIC PATIENT

Unsuspected diabetic patients in the main are adults or in the older age period of life. They may, however, present themselves in the juvenile years. Recently I observed a youngster who had just reached his sixteenth year. A year prior to the time I saw him he complained of weakness and inability to carry on his school work and usual activities. His father has diabetes and checked the son's urine when he checked his own. He found sugar. The boy was placed on a simple restricted diet by his father and all his symptoms cleared up until a week before I saw him. Again he was complaining of weakness, lethargy, inability to concentrate, and other symptoms but he had none of the cardinal symptoms of diabetes —polyuria, polyphagia, and polydipsia. Had this lad's father not been a diabetic patient, in all probability he would not have been picked up by the average practitioner because he did not present the usual symptoms of diabetes. He might have been placed upon a tonic and told to return later for observation. While this is not common it does occur. The result would probably have been that he would have developed an acidosis and probably coma before his true state would have been discovered.

I had a similar experience many years ago. I saw a young lady who presented symptoms of duodenal ulcer but none of the usual symptoms of diabetes. I had just outlined for her a full schedule of interval feedings when I noticed from the laboratory report that she had a large amount of sugar in her urine. Upon closer questioning she admitted that she had to get up once a night with her kidneys but had attached no significance to it. She did have a family history of diabetes. This experience years ago taught me to pay more careful attention to a patient's anamnesis.

Let none of us think of diabetes only in terms of frequent urination, excessive thirst, excessive eating, and loss of weight. These are later manifestations of an established insulin insufficiency. Let us always keep in mind the possibility of diabetes. It is much more common than we realize, and the early cases, especially in younger people, are those in which treatment achieves the greatest results.

The older patients, particularly the middle aged group and still more especially the obese middle aged group, are the unsuspected diabetic sufferers who are grossly neglected. It may be safely said that roughly 80 per cent of adult diabetic patients give a history of obesity. Dublin and Marks[1] of the Metropolitan Life Insurance Company found that of more than 4,500 diabetic patients aged 20 and over, 78.5 per cent of the males and 83.3 per cent of the females were overweight (at least 5 per cent above the average weight for age). A maximum weight of a patient may be sustained for a considerable period of time and there may set in a gradual weight loss with or without concomitant diabetic symptoms. Such patients may complain of loss of endurance; they may complain of just a sense of not feeling as well as usual. Too often these patients are merely given tonics or vitamins or other prescriptions and told to report back for further observation if not improved. Too often we doctors are guilty of not having a simple urinalysis on such patients.

I recall seeing several months ago a man, aged 53, whose weight was 306 pounds, 6 feet 3 inches tall, a ranchman, who had lived in the saddle for many years working his cattle and who came to me because he was not sleeping too well and had noticed that he seemed to tire more easily than he had heretofore. His family history showed diabetes in the background. While he was of large frame he was generally too fat, especially in the abdomen. Routinely a urinalysis was done and showed 3 to 4 plus sugar. He had not developed a frequency of urination nor did he complain of any of the other cardinal symptoms of diabetes. A blood sugar test showed 320 mg. per 100 cc. fasting. This man was not placed upon insulin but upon a rigid reduction diet. He lost down to approximately 225 pounds with the result that his fatigue disappeared and he felt himself again. No sugar was found in his urine and his blood sugars were normal fasting and following breakfast. This man may have been placed upon insulin and nothing might have been said of his weight. That is not the way to treat such cases; it is poor medicine.

This example is the typical unsuspected diabetic patient. We physicians are derelict in our duty if we fail to do a urine examination and still more important an after breakfast blood sugar test in an obese patient presenting a family history of diabetes. The patient may have a relatively high kidney threshold, and it has been my practice for many years to do a blood sugar test where I have reason to suspect a diabetic state masquerading in the form of muscle cramps, lack of well being, and so on in older persons, especially of the vascular sclerotic age period. More often than not their blood sugars are found to be abnormally high. These people must be told of their trouble. They must be made to reduce their weight. Other members of their family who are obese should

be checked by their family physicians to judge whether or not a similar condition exists. This is preventive medicine; this is good medicine and the sort to practice.

Many times I have seen patients who are taking insulin one, two, or three times a day who are obese and who may or may not have had symptoms of diabetes especially when they are in the middle age group. Often by weight reduction they can be taken off insulin entirely. Recently I saw a woman, aged 52, who was taking three injections of insulin a day. She was only about 5 feet 2 inches tall and weighed 183 pounds. During the period observed she was placed upon a reduction schedule and all insulin was stopped. Her fasting blood sugar when she was first seen ranged from 142 to 180 mg. per 100 cc. After several days on her reduction schedule and loss of several pounds she was discharged with a fasting blood sugar of 123 mg. She is still losing and her blood sugar is still down and she is doing without insulin. Incidentally, in this patient there also existed a hypertension which likewise came down with weight reduction.

I cannot emphasize too strongly the question of obesity. As was stated earlier, it is one thing about which we can do something. It is closely tied up with diabetes, and even though it is of perhaps the same hereditary origin as diabetes we can do something. Great strides can be made in preventive medicine by maintenance of average weights.

KNOWN DIABETIC PATIENT

Each one of us who treats diabetes should maintain a check list to assure himself that everything has been said and taught to the diabetic patient that will provide for him greater protection and a more wholesome life. Some of the more important items follow:

1. Each diabetic patient should be encouraged to develop a wholesome philosophy. He should be taught that diabetes is not a disease, that it is just a functional disorder, a functional deficiency of insulin. Parallels may be given of thyroid insufficiency or ovarian insufficiency. Furthermore he must be made to understand that there is no stigma, that there are well over a million such cases in this country. He should likewise be told that he can do what anyone else can do in the way of activities. References to such persons with diabetes as William F. Talbert, world tennis champion, are convincing. Finally, it should be impressed upon him that with reasonable care he can live his normal life expectancy.

2. The diabetic patient should be taught food values. He should know how to figure his own diet or, if he is too young, some responsible person in the family should be given this charge.

3. The patient with diabetes should be taught meticulously about insulin: what it is, where it is obtained, how it should be given, and what insulin reaction is. Especialy should he be taught that a unit of insulin is a unit of insulin whether it is U 20 or U 40 or U 80. While it is important that he understand U 20 means 20 units per cubic centimeter, U 40 means 40 units per cubic centimeter, and so on, he likewise must understand that each unit has the same strength regardless of its concentration. The greater concentration only makes it possible for a patient who is getting a large number of units to take less volume. Manufacturers of insulin sometimes make up a specially prepared concentration of from 250 to 500 units per cubic centimeter, which would be U 250 and U 500 respectively. Such an understanding of the insulin unit provides greater elasticity in the use of insulin.

The diabetic patient should be taught how to give insulin, especially the mixed insulins. It should be explained that different spots should be used for injections in order to avoid areas scarred by repeated injections. Although it is easier to give injections there than in more normal parts of the skin, one cannot be too sure about insulin absorption. There are simple tricks for inserting the needle relatively painlessly such as rubbing briskly the place where the injection is to be given. The brisk rubbing actually causes a local anesthesia or numbing of the skin.

The diabetic patient should be thoroughly acquainted with the problem of acidosis and insulin reaction and understand the differentiation between the two conditions.

4. The physician himself should be careful about making too frequent dietary changes and, still more important, changing insulin dosages too frequently. This practice of changing diet and insulin dosage frequently only results in a fluctuating blood sugar, thus bringing about either insulin reaction or excess amounts of sugar in the urine. Such cases are difficult to level off. The doctor should be familiar enough with insulin and its administration to wait for the patient's physiologic processes to adapt themselves. Changes in diet or insulin should be made slowly and with respect for the insulin that is being given. In this way the regulation becomes much smoother and certainly much more successful.

5. The patient with diabetes should be told what should be done and what might happen in case acute infections make their appearance. This is a contingency that is often not gone into with the patient, and when he does get an acute infection and begins to spill sugar, he becomes rather panicky. My usual routine is to tell the patient to maintain his carbohydrate level with fruit juices and other liquids, disregarding the protein and fat levels during acute phases of infection, and to maintain the same insulin

dosage. This procedure will take care of most acute infections satisfactorily.

6. The urine of diabetic patients should be kept as near free of sugar as possible. This is where most doctors who treat diabetes err. While it is impossible to keep the urine free of sugar all of the time and perhaps it is not advisable to try to do so, it is highly necessary that the patient lose a minimal amount of sugar. The ideal management of any diabetic patient is that he lose in twenty-four hours 10 per cent or less of the total glucose intake. Such optimum regulation can be reached in every diabetic patient by one means or another. If it cannot be done by slow acting protamine zinc insulin alone, it can be done by the combination of protamine zinc and regular insulin most effectively in the ratio of 1 to 2. Frequently globin insulin brings about optimum control.

7. Efforts should be directed toward avoiding arterial degeneration. This complication has become the greatest problem in managing diabetes. Approximately 65 per cent of present day diabetic patients die as a result of degenerative vascular disease.[2] As a rule, careful direction and proper care minimize the appearance of vascular degenerative changes in the diabetic patient, and unfortunately just now this hope is all we can offer him. Jackson[4] of Iowa City has indicated that poorly controlled juvenile patients with diabetes exhibit vascular lesions shown by ophthalmoscopic or soft tissue roentgenograms while well managed patients do not exhibit the same evidence of vascular degeneration.

In attempting to obtain effective control the physician should ask himself: Have I emphasized to the patient the necessity of maintaining a "normal" average weight? Have I taught him how to test his urine for sugar and acid bodies? Do I have him keep regular checks on his urine? Do I direct him to keep a record of the tests and, in the case of a child, a record of weight and growth? Do I encourage him to participate in all school sports? Do I watch his physical development? Have I warned the patient about the proper care of his feet, especially how to cut his toe nails?

These are only the essential things that every diabetic patient should know and know well. He is entitled to have all of this thoroughly digested and presented to him. The result is a self-confident patient, one who enjoys a latitude of care of himself without fear. Unless we as doctors are giving to our patients known to have diabetes such meticulous information for their care we are neglecting them.

8. Finally, every diabetic patient deserves careful over-all guidance. Good care includes taking chest roentgenograms and giving careful physical examinations because a person with diabetes can have other things. Administration of some form of vitamin B is recommended because there is reason to believe it aids in the utilization of sugar. Good care includes close contact with the patient either by telephone or letter or by visit.

CONCLUSION

Figures on the death rate of the nation have recently been released from the United States Office of Vital Statistics. In 1946 the rate was 997.6 per 100,000. In 1947, 1,007.8 per 100,000 excluding the armed forces. Almost a third or 31.9 per cent of deaths were due to diseases of the heart. Deaths from cancer, diabetes, and apoplexy increased. It is not unlikely that diabetes may have been tied up with some of the heart deaths as well as some of the apoplectic deaths.

We make every effort to prolong the life of a patient with cancer or chronic leukemia. If we fail to do everything possible in order that a patient with diabetes might live to realize his expectancy, we actually contribute toward a premature death; we ruthlessly rob him of one or many years of life. Generally, only the well controlled diabetic patient may expect to live to normal expectancy and without premature arterial degeneration. Unless we as doctors are interested in diabetes and its behavior, unless we know how to care properly for the diabetic patient, we are violating the trust that such a patient places in us.

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Code of Ethics for Medical Writers

The National Association of Science Writers has requested the help of the American Medical Association in drafting a code of ethics for medical writers, and Dr. Louis Arthur Buie, Rochester, Minn.; Dr. Austin Smith, assistant editor of *The Journal of the American Medical Association* and secretary of the A.M.A. Council on Pharmacy and Chemistry; and Dr. Percy E. Hopkins, Chicago, have been appointed by the executive committee of the A.M.A. Board of Trustees to work with the science writers. Lawrence W. Rember, director of A.M.A. public relations, and John L. Bach, head of the A.M.A. press department, will serve as ex-officio members of the committee.

Representatives of the National Association of Science Writers indicated that the proposed code of ethics would help both the medical profession and magazine and newspaper science writers in disseminating medical information to the public.

DIABETES MELLITUS AND PREGNANCY

ORAN V. PREJEAN, M.D., and JACK B. GRIFFIN, M.D.,
Dallas, Texas

THE present day management of pregnancy associated with diabetes dates from the discovery of insulin by Banting and Best in 1921. Before the advent of insulin, pregnancies complicated by diabetes were so rare that J. Whitridge Williams was able to collect only 65 cases in the entire world's literature in 1909. Of these 25 per cent of the mothers and about 50 per cent of the infants died. The main reason for this small number of pregnant diabetic women was that the great majority of diabetic women were sterile. The factors involved were thought to be (1) structural changes in the reproductive organs of women with diabetes; (2) hyperfunction of the anterior pituitary gland; and (3) nutritional deficiencies caused by the restricted diets which entailed reduction in food elements essential for reproduction.

The experience of this pre-insulin era has a clinical importance in that it demonstrates strongly that pregnancy and untreated diabetes are basically incompatible. The uncontrolled disease disrupts the reproductive mechanism and makes successful childbearing almost impossible. On the other hand, untreated diabetes is aggravated by pregnancy to a degree which is often fatal. Prior to the advent of insulin, the incidence of pregnancy in diabetic women varied from 2 to 6 per cent. With the discovery of insulin, however, the incidence varies from 15 to 30 per cent. In the period between 1936 and 1946, 227 married diabetic women between 15 and 45 years of age were admitted to Johns Hopkins Hospital. Sixty-five or 28.6 per cent were pregnant. In this period, there were 18,225 deliveries, of which the incidence of diabetes was 1 in 282 deliveries. This figure is higher than average, however. The practitioner may expect to encounter diabetes complicated by gestation about once in every seven or eight hundred pregnancies. This figure is small because diabetes tends to occur in an older age group and is more common after the menopause.

BAYLOR HOSPITAL SERIES

In the Baylor Hospital series from 1939 through 1948, there were 32 recorded pregnant diabetic patients with a total of 35 pregnancies. During this period there were 29,145 deliveries. The incidence of pregnant diabetic women in the period 1945 through 1948 was 1 in 780 deliveries. The patients' ages varied from 18 to 38 years with a mean age of 30 years. The duration of diabetes ranged from its discovery during pregnancy to twenty-five years. Parity varied from 0 to 10 with 60 per cent nulliparous. Gravidity varied from 1 to 11 with 50 per cent being primigravida.

During the prenatal period there were 16 patients with controlled diabetes and 19 patients in whom the disease was poorly controlled. Ten patients developed insulin reactions. In this series there were 1 spontaneous abortion at three and one-half months and 8 therapeutic abortions. One of these was performed because of an associated hypertensive heart disease and renal insufficiency. Four "therapeutic" abortions were done because the diabetes was not well controlled. The other 3 abortions were performed solely because the women had diabetes. There were 6 stillbirths. One was premature. One mature stillbirth occurred with an associated preeclampsia and ablatio placenta. Another occurred with uncontrolled diabetes in a patient receiving neither prenatal care nor diabetic therapy. The fourth stillbirth was associated with cephalopelvic disproportion, prolonged labor, a difficult forceps delivery with Dührssen's incisions, and impacted shoulders. There was no apparent explanation for the fifth stillborn infant. The sixth stillbirth was delivered elsewhere and details were unavailable. There were 2 neonatal deaths. One occurred in an infant delivered at six and one-half months by cesarean section because of preeclampsia. The other infant was born prematurely at seven months with deformities and hydramnios.

In this series there were 6 premature and 12 mature living babies. From the 19 uncontrolled diabetic mothers, there were 8 living babies. From the 16 controlled diabetic mothers, there were 10 living babies.

Excluding the 9 abortions, there were 18 living babies out of a total of 26 pregnancies, or an incidence of 68 per cent, which compares favorably with the present national incidence. There were 9 abortions, of which only 1 was spontaneous. There were 15 vaginal deliveries and 11 cesarean sections. There were 6 breech presentations and 7 tubal ligations.

The duration of pregnancy varied. Five patients went to term with 3 living and 2 stillborn children. Six were delivered at eight and one-half months with 4 stillborn infants. Ten were delivered between six and one-half and eight months with 2 neonatal deaths. The infant birth weights were greater than normally noted for babies of nondiabetic mothers

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for the given period of gestation, and this was more evident in the weights of the babies delivered before term. The average weights were as follows: at term, 8 pounds 15 ounces; at eight and one-half months, 8 pounds 10 ounces; at eight months, 8 pounds 13 ounces; at seven months, 6 pounds 7 ounces.

Toxemias of pregnancy were frequently encountered and presented a problem. There were 7 patients with preeclampsia, mostly severe, and 2 patients with eclampsia, giving an incidence of 1 in 3 patients. Ten patients had prenatal insulin reactions and 1 patient had an associated hypertensive heart disease. This pregnancy was terminated at three months. There were 2 recorded cases of hydramnios. There was 1 maternal death, but the exact cause was never definitely determined. The postpartum course was normal until the seventh day, when the patient suddenly developed convulsions and fever and died within twenty-four hours. The blood pressure remained normal.

The following complications were encountered: pruritis vulvi, postsurgical atelectasis, thrombophlebitis of the left leg, postsurgical lung abscess, and a congenitally deformed baby with an associated hydramnios.

EFFECTS OF COINCIDENT DIABETES AND PREGNANCY

It is a well established fact that arteriosclerosis as well as atherosclerosis occurs in diabetes. This involves the vessels of the eyes, heart, aorta, extremities, and brain, as well as the vessels of the kidney, thereby producing an intracapillary glomerulosclerosis.

In pregnancy, a lowered renal threshold, as well as reduced sugar tolerance, is frequently noted. In late pregnancy, lactosuria may be encountered. Glycosuria and lactosuria may confuse the diagnosis of diabetes or may be associated with this disease, thereby presenting a problem in the management of the disease. Blood sugar levels as well as urine sugar determinations must be ascertained to evaluate properly the control of the disease.

The primary effect of pregnancy on diabetes is to render the disease more difficult to control. This difficulty is due to the interaction of a number of factors summarized by Eastman as follows:

1. Changes in sugar tolerance:
   a. The sugar tolerance may be diminished and more insulin required, due, supposedly, to the increased activity of the anterior pituitary gland.
   b. The sugar tolerance may be increased and less insulin required, due either to activity of fetal pancreas or to other factors.
   c. Losses of unknown amounts of carbohydrate food in vomiting may simulate raised sugar tolerance, provoke acidosis, and confuse the dietary picture.
   d. The muscular exertion in labor may deplete the glycogen reserve and alter the carbohydrate and insulin requirements.
   e. A gain in sugar tolerance often occurs after delivery, and hypoglycemia in the puerperium is common. It may be associated with vacillations in blood sugar due to the reconversion of bodily mechanisms to their nonpregnant state. Lactation, with conversion of some blood glucose infection may precipitate acidosis and coma with great rapidity.
2. Increased tendency to ketosis:
   a. The diminished carbon dioxide combining power of the blood in pregnancy makes gravidae less resistant to acidosis.
   b. The elevated basal metabolic rate in pregnancy increases the tendency toward acidosis.

The effect of diabetes on pregnancy, on the other hand, depends largely upon the extent to which the disease is controlled. While the deadly consequences to the fetus associated with neglected diabetes may be diminished by careful regulation, it still must be remembered that diabetes is unfavorable to successful pregnancy. Even with the best modern care, the harmful influences of diabetes often make their appearance, causing a greatly increased stillbirth and neonatal death rate.

Eastman summarizes the effects of diabetes on pregnancy as follows:

1. The incidence of spontaneous abortion and premature delivery is slightly increased.
2. The frequency of toxemia is greatly augmented.
3. Fetal death in utero before the onset of labor is more common in diabetic than in normal pregnant women.
4. The incidence of larger-sized infants is increased with the result that mechanical difficulties in labor are more frequent and abdominal delivery is more often necessary.
5. Hydramnios is more common.
6. Congenital malformations are more frequent, occurring in about 2 to 3 per cent of the reported cases, and contribute to a certain number of fetal deaths and hydramnios.
7. Lactation may be diminished in some cases, although successful lactation has been reported by some authors.
8. The neonatal period is associated with especial hazards in the form of hypoglycemia and anoxia.

In addition to these, there are still two other factors which may influence pregnancy in an indirect way. They are age and obesity, remembering that the average age of diabetic gravidae is usually 30 years and many persons with diabetes are overweight.

Smith and Smith have presented evidence that in diabetic pregnancy toxemia the chorionic gonadotrophic level is usually high and the estrogen and progestin levels are low, although the shift in balance antedates the actual development of toxemia by some weeks. This work was put to clinical test by Priscilla White.

The signs and symptoms of diabetes in pregnancy are manifested in various forms. In a small percentage of patients, diabetes is first recognized during pregnancy. The usual symptoms of diabetes, namely, polydypsia, polyuria, polyphagia, pruritis, loss of weight, lassitude, irritability, and even coma, may manifest the disease. In many well-controlled diabetic patients the first indication of pregnancy may be an insulin reaction or an altered urine sugar and blood sugar level along with amenorrhea, nausea, and other changes. Glycosuria, elevated blood sugar, evidence of toxemia of pregnancy, and antenatal fetal death may occur. Priscilla White has demonstrated that roentgen-ray evidence of calcification of the pelvic vessels is an ominous sign for the fetus.

PRENATAL CARE

The pregnant diabetic patient must be carefully observed throughout pregnancy and the diabetes must be rigidly controlled in the hospital if at all necessary. It is advisable that blood sugar levels supplement urine sugar determinations since the latter may be misleading because of the physiologically increased glycosuria in pregnancy. With the occurrence of insulin reactions the insulin dosage should be readjusted to allow a slight glycosuria if necessary. The patient should have a liberal carbohydrate intake so as to prevent ketosis. White recommends from 30 to 40 calories per kilogram of body weight, including from 150 to 250 Gm. of carbohydrate and 2 Gm. of protein per kilogram or from 80 to 100 Gm. of protein and fat to complete the caloric intake.

If vomiting is severe in the first trimester of pregnancy, acidosis may become extreme. Immediate hospitalization is advised with hourly feeding and intravenous glucose and insulin given as required. In the last trimester observation must be made constantly for sugar tolerance changes and signs of toxemia. The sodium intake should be restricted and fluid balance and hydration carefully controlled. The patient must be observed for evidence of hypertension, weight gain, edema, or hydramnios and cautioned as to toxic symptoms. In accordance with the work of Smith and Smith and Priscilla White, many physicians now administer stilbestrol and progestin daily during the entire pregnancy. The daily dosage of progestin varies between 5 and 50 mg. parenterally and of stilbestrol, from 10 to 50 mg. parenterally or from 40 to 120 mg. orally daily. Usually 5 mg. of each is administered intramuscularly daily until the twentieth week, at which time the daily dose is increased by 5 mg. every succeeding four weeks.

Diabetes per se is not considered an indication for therapeutic abortion.

DELIVERY

Most of the fetal deaths occur in the last month of pregnancy. This has led many obstetricians to terminate pregnancy at about the thirty-seventh week. Other factors influencing early termination are the presence of associated toxemia, an obviously large fetus, or inability to control the diabetes. It is advisable to put the patient in the hospital about three weeks before the expected date of delivery, or at any time that toxic signs develop. This is for the purpose of stabilization and for consideration of the mode and desirability and possibility of early delivery.

The obstetric evaluation should be done with particular reference to presentation, fetal abnormalities, development, and weight, and with estimation of the fetal size to the pelvis. A pelvic examination should be done to determine the position of the presenting part, the length and dilation of the cervix. If the head is at or below the spine, the cervix admits one finger and is less than 1 cm. in length; providing there is no fetopelvic disproportion, the membranes may be stripped back and ruptured, and the patient allowed to deliver vaginally. If the cervix is not wholly favorable for induction, a cesarean section may be considered.

Advocates of cesarean section point out that the infant is likely to be large, with consequent mechanical difficulties in labor, and these babies inherently tolerate labor poorly. In cesarean section no preliminary medication is given; spinal anesthesia is the anesthesia of choice with the patient getting oxygen during the operation. It must be remembered that there are equally strong advocates for allowing the patient to go to term and deliver vaginally or to do a cesarean section only as obstetrically indicated and not because of the diabetes itself.

During labor, because of glycogen demand on the liver, glucose and insulin are given as indicated and the patient is given a minimum amount of sedation. Spinal or pudenal block or nitrous oxide are best used for the third stage of labor.

POSTPARTUM CARE

In the early puerperium diabetes may be difficult to control. There may be a wide fluctuation in the blood sugar level due to endocrine and metabolic changes, slight degrees of puerperal infection, and the conversion of glucose to lactose. The first postpartum week is the most critical for the mother and insulin reactions are frequent. The patient must re-

ceive close observation and care since persons with diabetes are inclined to be susceptible to reactions and infections, namely, puerperal, pulmonary, or of the vascular system. The intelligent, well-controlled diabetic mother may be allowed to nurse but care must again be exercised at the time of weaning.

The blood sugar concentrations of babies from diabetic mothers fall to lower levels than those of normal infants. These levels are normally low in the first two days of life.

The following hazards are usually encountered in babies of diabetic mothers: (1) over-sedation, (2) edema and fluid in the upper air passage, (3) lethargic state and cyanosis of undetermined origin, (4) hypoglycemia, (5) a state resembling erythroblastosis without anemia, and (6) atelectasis. It is therefore necessary to limit sedation, clean the air passages and assure drainage, give oxygen as indicated for cyanosis, and restrict fluids after delivery, dehydration and weight loss being welcome if the infant is edematous. Glucose, subcutaneously or orally, should be given if abnormal lethargy, cyanosis, or convulsive states appear. If dramatic improvement occurs with glucose treatment, it must be repeated at frequent intervals. Constant observation is imperative.

SUMMARY

Pregnancy and untreated diabetes are basically incompatible. Rigid control of the disease is imperative for successful reproduction. During the prenatal period close observation must be made for insulin reactions, toxemia, hydramnios, and fetal death. Evaluation of the patient and termination of pregnancy at the thirty-seventh week of gestation apparently gives the best results. Both the mother and the infant must be carefully observed in the immediate postpartum state as reactions, lethargy, coma, cyanosis, vascular and respiratory difficulty, and infections occur during this period. It is believed that a diabetic woman who becomes pregnant can usually be successfully carried to a stage of viability of the fetus and that therapeutic abortion is contraindicated.

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Dr. Prejean, 4317 Oak Lawn Avenue.
Dr. Griffin, 4407 Oak Lawn Avenue.

THE DOCTOR IN HIS RELATIONSHIP TO THE COMMUNITY

W. L. PRESSLY, M.D., Due West, South Carolina

I SPEAK not in a personal or individual but rather in a representative capacity. In accepting the award as General Practitioner of the Year from the American Medical Association, I stated that I did not regard it as having come to me personally, but to me as the representative of the 130,000 general practitioners. To be the representative, even for a short time, of this company of splendid men gives one a feeling of great responsibility, for while I personally am not important, this group which for a brief period I represent is important. It is an integral and essential part of the medical fraternity and from year to year renders a conspicuous service in its ministry to suffering humanity.

Frequently in this day we are reminded that the horse and buggy days are gone, and that the old fashioned country doctor exists only as a memory. In one sense this is true. Many things that characterized the life of the horse and buggy doctor have departed with the horse and buggy. Life with us today moves too rapidly for the doctor to spend all day with one patient and all night with another—in each case serving as both doctor and nurse. Likewise good roads, modern communications, modern conveniences, and easy access to well equipped hospitals have made it unnecessary "to perform operations by candlelight and under the crude conditions of country homes where almost any case was an emergency." In like manner our modern educational system has brought the advantages of high school and college education to vast multitudes. Hence, the doctor is no longer one of the few educated men in a community and, consequently, he is not expected to counsel and advise along as many lines as formerly. In these and other respects much that characterized the ministry of the country doctor has passed.

However, let us not think that all that characterized his life has passed or should pass. Many things that

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were strikingly manifest in his practice we today should seek diligently to preserve. In an editorial in the Halifax *Gazette* regarding the late Dr. I. K. Briggs of South Boston, Va., described as "one of the few country doctors left," some of the abiding things we need to cultivate are made clear:

"Dr. I. K. Briggs, a servant of the people, passed on to Eternal Sleep Tuesday. The man and his little black bag, moving silently and unpretentiously among his people, healing wounds and mending broken bodies, bringing health and hope to thousands—he was accepted as much a part of this community as the time-worn landmarks that identify this community as home.

"He was more than just a doctor. Ask anyone of thousands about that. Neither storm nor darkness deterred him from calling on those who needed him. Nor did his personal comfort and health count for much when it came to fulfilling the mission to which he had dedicated his life. He was literally worn out before his time because others needed him more than did the demands of his own well-being. If there was sickness or injury, Dr. Briggs was ever ready to administer the fine knowledge he possessed of the curative powers of medicine and surgery.

"His life and nearly all of his energy was dedicated to the ministry of healing the sick and wounded. Other things were trivialities to him. There were so many who needed him and he could not escape a deep sense of responsibility to them. How seldom does one find such consecration to duty. Yet, withal, he was a lovable person."

Here, as we see, this editor makes emphatic certain abiding characteristics. His interest in and love for the people among whom he lived and to whom he ministered; his unselfish, self-sacrificing devotion to duty, ever placing another's need above the demands of his own well-being; his recognition of the claims of obligation and responsibility—these were the thoughts uppermost in the minds of men long after "the sunny beaches and the tantalizing blue waters of the great Beyond" had beckoned Dr. Briggs.

These words "obligation" and "responsibility" should never be lightly pushed aside. They apply to the community in its relation to the doctor as well as to the doctor in his relation to the community.

OBLIGATIONS OF COMMUNITY

The community discharges its obligation in part, at least, by the special privileges granted to the doctor. The doctor is allowed to practice in a manner he believes to be wise, without restraint or direction. His statement as to the cause of death is accepted without question. A simple statement from him that a juror, a witness, or even the defendant is too sick to continue is sufficient to postpone or even stop a trial. He is not subject to jury duty, and he is not criticized if, instead of going to church, he sits in the staff room and chats with his colleagues during the church hour. During gasoline rationing, he set his own figure as to his needs, and he was not too harshly criticized if he overestimated a little at times.

Too, the community gives to the doctor its confidence and respect. He is entrusted with the most intimate details of the personal and family life of his patients. Indeed, the most sacred interests of their lives are entrusted to him. They respect his judgment and listen with approval to his opinions. His fellow citizens are hard to convince that he is not the kind of man they have come to expect in the profession of medicine. It has come to be and it still continues that these privileges, this respect and indulgence are recognized obligations of the community to its doctors.

Then, there are other privileges which are not so widely accepted by the layman but are becoming more universally demanded by the profession. These have to do with the matter of charges for services, hours of work, vacations, and choice of patients. These have to do also with educational and cultural opportunities and with physical equipment for the widest and largest use of their technical skills. The well-trained, conscientious doctor may reasonably expect of his clientele that they realize he is not selling commodities, but is dispensing to rich and poor alike a highly specialized service. In order to render this service to the poor in the most effective way it is necessary that there be adequate and accessible hospitals. These are privileges which have to do with the material aspect or the business side of medicine. While essential, we must confess that they tend to slip in between the doctor and his one time adulating public.

As one of my doctor friends expressed it, "There is great danger because of the doctor becoming so economic conscious, so intent on providing well for his family both before and after his death, so determined not to be taken in by the dead-beat, so careful to guard his health by adequate unbroken sleep, by regular afternoons off, by periodic vacations, and ultimately to postpone an early death by that great destroyer of physicians, coronary disease, that he ceases to be a servant of the people to be turned to in time of trouble and becomes instead a public utility, without government supervision or regulation. And when that time comes, the doctor relinquishes his eminence, gives up his hero worship, and comes to be grumbled at and against just as is the transportation system or the telephone service."

Hence, we should be honest with ourselves and with one another as we face the truth that the doctor, in exchange for his privileges and his adoration must, if he would retain this attitude peculiar to his profession, recognize that he too has obligations of a definite character to his community.

OBLIGATIONS OF PHYSICIANS

No doubt it was with this idea in mind that the second annual meeting of the World Medical Associa-

tion, held in Geneva in September, 1948, sought to revive the old oath of Hippocrates. This old oath has been somewhat revised and now has the name of Geneva associated with it. It is to be made available in the appropriate languages to all the doctors of the world. Furthermore it is believed that its acceptance by the oncoming generations of doctors in every land will do much to raise the standard of medicine throughout the world. Here is the ten point oath, as published in the March, 1948, issue of the *World Medical Association Bulletin,* which is to be administered at the time one is being admitted as a member of the medical profession:

1. I solemnly pledge myself to consecrate my life to the service of humanity.
2. I will give to my teachers the respect and gratitude which is their due.
3. I will practice my profession with conscience and dignity.
4. The health of my patient will be my first consideration.
5. I will respect the secrets which are confided in me.
6. I will maintain by all the means in my power, the honor and noble traditions of the medical profession.
7. My colleagues will be my brothers.
8. I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient.
9. I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.
10. I make these promises solemnly, freely and upon my honor.

This is a searching oath. By it definite obligations are imposed. By it the medical profession is challenged to set for itself a high standard. Guided by its principles the doctor would be strengthened in fulfilling the obligations that rest ever upon him.

The obligations of a doctor are not confined wholly to those in line with his profession. He is also a citizen. He belongs to the educated, the best trained group in any community. He has been trained to take leadership, to think logically, to make quick decisions based on observation and logical deduction. Such a person owes it to his community to use those powers in community betterment in other realms besides that of medical care. As the doctor grows older, having left behind the long years of training in school, in hospital, and in early practice; having so served through the packed and crowded years of professional maturity as to win the confidence and esteem of his fellow citizens, he is better able to make his influence count in the things that strengthen and build the community. Released from some of the duties that bound him, he should give more of his time, his energy, and his ability to becoming a great citizen and thereby help to make of his home town a great community. He who is permitted so to do need never fear the changing attitude of the people toward their doctors. Best of all he will find his life filled with those "durable satisfactions" which are the by-products of a work well done.

Betatron Therapy for Glioblastoma

A patient suffering from glioblastoma was the first to be treated with 20,000,000 volt roentgen rays and with the betatron, an apparatus for the production of high electron beams with deeply penetrating power, reports the May issue of the *American Journal of Roentgenology.*

Although the patient died a month after the institution of betatron therapy, the eighteen doctors, who spent about 2,000 man-hours in the treatment of the case, concluded that betatron should produce an increased number of cures of deep-seated tumors and decreased cases of radiation damage.

The authors of the report concluded that with high energy rays it is possible to treat any region anywhere in the body with high doses without reaching dangerously high levels outside the predetermined region. "It is feasible," they wrote, "and it may be desirable in selected cases, to achieve a caustic or almost caustic effect in the depth. With low energy equipment, this can be done only in accessible regions of the body."

Conclusions drawn from the autopsy were that "it can easily be seen that the betatron offers good methods for tumor regions of any shape and in any position in the human body."

"High energy roentgen rays, whether produced by the betatron or other machines, gives us the possibility of nearly perfect geometric selectivity. In order to realize this possibility, one must use precision methods of aligning the patient with the beam."

Beryllium Not Cause of Lung Disease

Beryllium introduced into the body by cuts from fluorescent light tubes apparently does not cause generalized lung disease, which is believed to result from inhaling beryllium compounds. Writing in the July 9 *Journal of the American Medical Association,* Drs. A. D. Nichol and Raphael Dominguez of St. Luke's Hospital, Cleveland, Ohio, state that "generalized pulmonary granulomatosis has not been reported to follow the accidental introduction of beryllium into the skin or subcutaneous tissues."

"Although chronic pulmonary granulomatous disease has not been produced experimentally, we believe that the study of instances of cutaneous involvement lends additional support to the clinical evidence that beryllium is at least a major factor in the causation of a disease which may cause extensive change in several structures of the body," they add.

"Chronic persistent granulomatous inflammation of the skin with ulceration may follow accidental lacerations by the present type of fluorescent light bulbs. Prevention of the cutaneous lesions can be accomplished only by wide excision."

Every case of tuberculous meningitis in childhood should be regarded as a pointer to a dangerous open case of respiratory tuberculosis in the immediate entourage of the sick infant; this case should at once be sought and the appropriate action taken when found, writes Dr. C. O. Stallybrass in the February 5 issue of the *British Medical Journal.*

PREOPERATIVE MANAGEMENT OF THE JAUNDICED PATIENT

FRANCIS J. KELLY, M.D., Amarillo, Texas

THE surgeon has a twofold concern in patients with jaundice: (1) to ascertain whether or not the jaundice is hemolytic, hepatocellular, or obstructive in origin and (2) to give preoperative treatment for complications which might otherwise arise following surgery in jaundiced persons.

TYPES OF JAUNDICE

The most general classification of jaundice is based upon the principal etiologic factors involved: (1) hemolytic or hematogenous jaundice, which is due to the excessive production of bilirubin because of extensive hemolysis; (2) hepatocellular jaundice, generally due to a combination of defective excretion of bilirubin and defective reabsorption of bilirubin; and (3) obstructive jaundice, due to extrahepatic obstruction of the bile ducts. It is not the purpose of this paper to go into the various etiologic factors involved in each of these divisions of the classification.

Before operating upon a patient with jaundice it is important to rule out hemolytic jaundice or primary intrahepatic pathologic conditions. Today, of course, congenital hemolytic jaundice can be diagnosed with great accuracy and gratifying results can be obtained with surgical therapy. The diagnosis of congenital hemolytic jaundice, however, is no assurance that stones will not be present. Rassieur reported in one family 3 children under the age of 10 in each of whom gallstones were present at the time of splenectomy for familial hemolytic jaundice.

The attention of the surgeon is directed to primary liver damage only insofar as the difficulty in diagnosis is concerned. In the face of persistent jaundice, though the physician may soundly favor the diagnosis of a primary hepatogenous jaundice—he can seldom be absolutely certain of his diagnosis—operation is frequently resorted to for fear that the patient does have an obstruction which can be relieved by surgical intervention.

The production of the extrahepatic or obstructive type of jaundice may be due to one or more of the following pathologic states: (1) calculi in the biliary tract; (2) carcinoma of the pancreas, gallbladder, or bile ducts; (3) congenital atresia, usually involving the common bile ducts; and (4) acquired benign strictures of the duct due to adhesions or extrinsic pressure on the duct from tumors.

Read before the Potter County Medical Society, May 9, 1949.

PREOPERATIVE MEASURES

The first operation on the gallbladder in a jaundiced patient was performed seventy years ago by J. Marion Sims. Until relatively recent times, however, a high mortality was reported following surgery of the jaundiced patient. The fundamental pathologic physiology is not yet completely understood. Certain principles regarding the preoperative and postoperative management of jaundiced patients have evolved, however, thereby lowering markedly the surgical mortality. The increasing success with this type of surgery is due primarily to the completeness and thoroughness of the preoperative care. Ordinarily, for adequate preoperative treatment it is necessary that the patient be in a hospital for at least five days prior to surgery. Hepatic insufficiency or "liver death" and hemorrhage are the main causes of death after operative procedures in jaundiced patients. Fatalities due to hemorrhage are still being reported. However, with further study of the cause of hemorrhage, this tragic sequel to an otherwise successful operative procedure is being seen less frequently.

A thorough understanding of the physiology of the liver is a prerequisite for the understanding of many of the principles involved in preoperative care as the liver is the one organ in which most, if not all, of these destructive processes are taking place. As far as possible, of course, the whole organism must be treated, for damage may have been done to organs other than the liver as a result of the disease. The patient must be fortified to withstand the operative measures necessary for a radical control of his disease and a reserve must be built up to supply the needs of the body during the immediate postoperative state. It is now known that the liver can be fortified against impairment of its functions through the use of specific measures.

Dehydration

Attention should be directed first toward any existing dehydration. Fluids should be given orally as much as possible. However, these patients are frequently extremely ill and it is necessary to resort to intravenous fluids. If protracted vomiting has taken place, saline solution is indicated; otherwise I prefer 10 per cent dextrose in distilled water, since the dextrose will be stored as glycogen. Another reason

for making certain of the proper fluid balance at the outset is to insure proper evaluation of the laboratory results as, for example, a total protein in the normal range in a dehydrated patient will be found to be dangerously low once the patient becomes adequately hydrated. This must also be kept in mind in the determination and evaluation of the albumin-globulin ratio.

Many of these patients will be found to have a moderate to severe degree of anemia, and it will be necessary to administer oral iron preparations and frequently whole blood transfusions.

Prothrombin Time

In obstructive jaundice fat soluble vitamin K cannot be absorbed from the gastro-intestinal tract as the presence of bile is necessary for this absorption; therefore the deficiency of vitamin K is frequently observed. The need for vitamin K can best be determined by ascertaining the prothrombin level in the blood. This determination should be made prior to any vitamin K administration so that the response to the vitamin may be observed as a guide to the condition of the liver insofar as its ability to respond to specific measures is concerned. Operation should be deferred until the prothrombin time approaches normal. The value of vitamin K in the preoperative treatment of these patients has been definitely established and certainly no justification can be found for operating upon a jaundiced patient without an exact knowledge of the prothrombin time and, if necessary, administration of vitamin K.

The prothrombin time can also be materially raised through the use of whole blood transfusions. In this connection it should be remembered that prothrombin is rapidly destroyed by an alkaline solution (citrated blood) and the blood should, therefore, be administered as soon as possible following withdrawal. It has been frequently observed that bleeding is more common in deeply jaundiced patients; however, the depth of bilirubinemia is not always the determining factor in the bleeding. The fact that there is no tendency to bleed in patients with hemolytic jaundice and that hemorrhage in patients with catarrhal jaundice is relatively rare also lends support to the evidence that liver damage accounts for bleeding. Mason and Zintel have termed this bleeding tendency "hemorrhagic hypoprothrombinemia." They pointed out that when the prothrombin level has dropped to a low of 35 per cent of normal, a hematoma may become evident at the site of a needle puncture. These hematomas are frequently the only outward clinical evidence of a dangerous tendency to bleed.

If vitamin K and blood transfusions still fail to raise the prothrombin level to a satisfactory point, as may occur, the risk of hemorrhage may be materially reduced by the intravenous administration of water soluble vitamin K just prior to surgery.

Protein Level

Elman and Heifetz in 1941 made apparent, through their experimental studies, the importance of protein in the protection of the damaged liver. Initially, it was believed that carbohydrates were the most important nutritional factor in the protection of the liver prior to operation. It has been shown (Elman and Weiner) that amino acids have just as important, if not more important, a place in the preoperative protection of the liver. In any event, it is necessary that the fat intake be markedly reduced. A high caloric diet of 25 per cent protein, 70 per cent carbohydrates, and 5 per cent fat will usually improve the condition of the liver.

In addition to fortifying the liver, adequate protein level is essential for proper wound healing. No organ can form new cells without adequate protein. Low protein may be the precursor to the hepatorenal syndrome. Certainly every patient suspected of liver damage should have the help of high protein administration, either orally or parenterally. Though the oral administration is possible, the quickest way of restoring protein insufficiency is by the administration of whole blood.

The use of lipotropic agents such as methionine and choline has been based on animal experimentation and observation on human subjects is still under investigation. Clinical results so far have not been too encouraging. It may be, however, that methionine will be found to have a specific detoxicating action under certain conditions and these types of drug may have a lipotropic effect. There may be a reasonable basis for the use of these substances if the patient has presumably a fatty liver.

It is my usual practice to supplement the above treatment with large quantities of vitamins. Especially is this true with vitamin B complex, which seems to be an essential part of the treatment. In patients showing evidence of osteoporosis, vitamin D and calcium salts are added.

In the presence of liver disease, of course, morphine is definitely contraindicated as approximately 90 per cent is detoxified by the liver. I now use routinely in jaundiced patients Demerol parenterally or orally in from 50 to 100 mg. doses. Barbiturates are also not well tolerated by a damaged liver and therefore should be used sparingly.

The careful preparation of jaundiced patients for surgery cannot be over estimated. A correct etiologic diagnosis will be of no avail if the physician neg-

lects to prepare the patient before surgery very carefully or if he fails to consider the patient's requirements.

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RECENT ADVANCES IN THE CHEMICAL SUPPORTIVE THERAPY OF THERMAL INJURY

CARL A. MOYER, M.D., Dallas, Texas

FOR over twenty centuries of recorded medical experience, men have been primarily concerned with the local treatment of the burned area and the control of the pain. Within the past thirty years much has been learned regarding the general physiologic consequences of thermal trauma. As this knowledge has been applied to the supportive therapy of the burned or scalded patient, the mortality rate has dropped.

The researches of Frank P. Underhill were the first to emphasize the treatment of the unburned parts of the body as well as those burned. The work of two Germans, Ricker and Regendanz, is the first carefully conducted study upon the immediate and delayed effects of heat upon the blood vessels and the flow of blood in the area of injury. Their observations are important because they provide the rational basis for the transfusion of whole blood.

PHYSIOLOGIC DERANGEMENTS

The physiologic derangements in the uninjured parts of the body that almost immediately attend the burn or scald are the loss of circulating red blood cells and the loss of extracellular fluid.

The reduction of the mass of circulating red blood cells is incident to immediate hemolysis,* stasic blood flow, the opening of capillaries, the dilatation of capillaries, and petechial hemorrhages in the area of injury (fig. 1 below).

The reduction of the circulating mass of red blood cells per unit volume of uninjured tissue by the above processes may amount to as much as 50 per cent within minutes. If the above statement is true, why does the corpuscular volume percentage rise? A rising percentage after a burn or scald signifies only that the reduction in the volume of the circulating plasma is greater than the reduction in the volume of circulating red cells per unit of time. Occasionally, a falling corpuscular volume percentage will follow a severe third-degree burn or scald; this means that red cells are being lost more rapidly than is the plasma—not that the plasma volume is increased following the burn.

In addition to the reduction in the mass of circulating red cells in the uninjured parts of the body, a rapid loss of extracellular fluid from the undamaged parts into the burned part takes place (fig. 1 above). This is first manifest by a reduction in the volume of plasma and later by a reduction in the extravascular extracellular fluid.

Since extracellular fluid is mainly a mixture of sodium chloride and sodium bicarbonate, the shift of extracellular fluid into the burned part represents a loss of sodium salts and water by the unburned parts. The water and salt in the cells cannot be drawn upon to mitigate the fall in the volume of the plasma and the volume of the extravascular extracellular fluid, and therefore the volume of intracellular fluid does not change appreciably.

The loss of plasma protein into the injured part is not as important physiologically as the loss of sodium salts into it.

TREATMENT

The immediate treatment of the burned person should be directed toward getting whole blood *and* sodium salts *and* water into him.

To give blood but to withhold sodium salts is inadequate treatment for the severely burned because it does not restore the volume of extracellular fluid. To give plasma, which is only salt water with a little protein in it, and not to give blood is inadequate treatment of the severely burned because it does not restore the lost red blood cells. To give blood and

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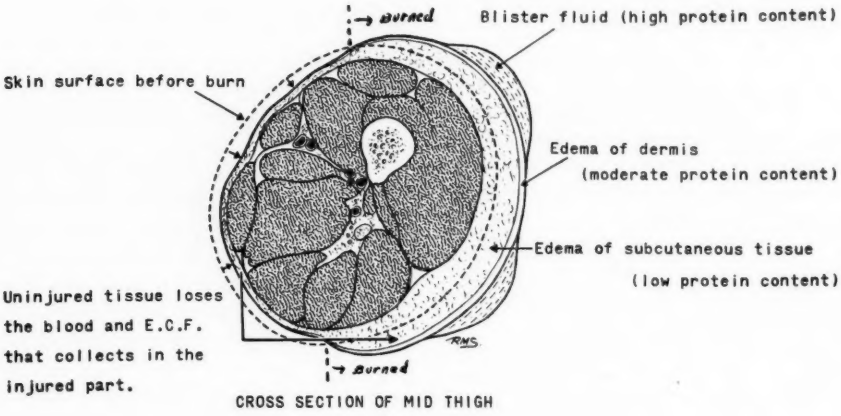
*The immediate hemolysis varies with the period of time that heat is applied to the body and with the area exposed. The immersion of two-thirds of the body of a dog in water of 85 C. for thirty seconds is followed within five minutes by the appearance of from 0.5 to 1.0 Gm. of free hemoglobin in 100 ml. of plasma; immersion for from three to five minutes is immediately followed by the appearance of from 3 to 6 Gm. of free hemoglobin in 100 ml. of plasma. The later hemolysis represents the distraction of from 10 to 20 per cent of all red cells in the animal's body.

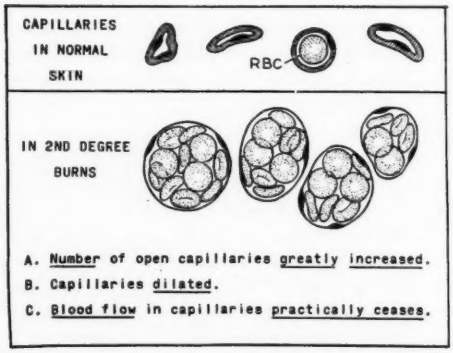
water without salt in it is also inadequate and is really dangerous.

Recent experiences have practically proved that the early "toxemic" phase of burns is mainly water intoxication and that it can be attributed to permitting the unlimited drinking of water before an adequate amount of salt is given.

The development of the early water-intoxicational or toxemic phase of burns is somewhat as follows: The burn is suffered and about the first request the burned person makes is, "water." He is given water, then more water, and then more water—it collects in his stomach and sodium salts enter it and are subsequently vomited. The water that held these salts in the plasma is left behind and dilutes the salts left in the body inside and outside of the cells. If the water is not held in the stomach but enters the intestine, it is absorbed and it dilutes the salts of the body. The kidneys will not put out this water until an adequate amount of sodium is given. Therefore, whether the water drunk be vomited or absorbed it serves always to reduce the strength of the salt water inside and outside of the cells. This dilution of the salts of the body is made manifest by falling plasma chloride and sodium concentrations. As the salts of the body are diluted by the water, headache, tremors, twitching, blurring of vision, vomiting, diarrhea, disorientation, salivation, and mania appear, and when the salts are diluted sufficiently, convulsions often begin. Therefore it is obvious that salt must be given with the water until the extracellular fluid volume of the uninjured parts has been restored toward normal.

Since the salt lost into the injured area is mainly a mixture of sodium bicarbonate and sodium chloride the salt mixture given should contain these substances. If only sodium chloride is given, acidosis is produced as the extracellular volume is built up. It takes a highly functional kidney to excrete chloride without sodium to make extracellular fluid out of a





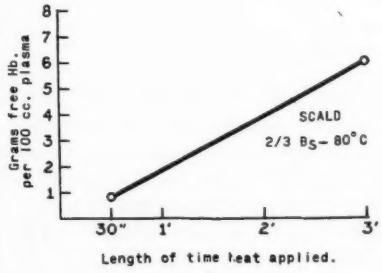


FIG. 1 above. Diagrammatic representation of extracellular fluid shift following thermal injury (second degree).

Below left. Graphic representation of capillary response to thermal injury showing loss of flowing red blood cells.

Below right. Graph showing hemolysis resulting from heat injury.

solution of sodium chloride. After a severe injury, the kidney will not do this. Consequently, isotonic sodium chloride is not the salt solution to give to the burned.

Simply adding from 3 to 4 Gm. of sodium chloride (1 teaspoonful) and from 1.5 to 2 Gm. of sodium bicarbonate or sodium citrate (⅔ teaspoonful) to each quart of drinking water makes a palatable and satisfactory solution to drink.*

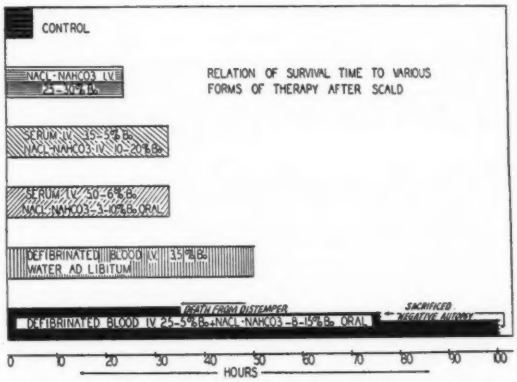


FIG. 2. Graph showing relation of survival time of dogs to various forms of therapy after scald.

Hartmann's solution (lactated-Ringer's) is suitable for parenteral administration. The intravenous route must be used for the administration of Hartmann's solution whenever peripheral circulatory failure (shock) exists because there will be little or no absorption from the subcutaneous tissues, gut, or rectum until blood flow is reestablished in these areas. After the pulse has fallen somewhat and the extremities have warmed up following the injection of blood and Hartmann's solution the sodium chloride-sodium bicarbonated water may be given orally ad libitum. No "real" water is permitted for from seventy to one hundred hours after the injury unless the signs of water need appear. These are severe thirst, dry mucous membranes, rising temperature, and plasma sodium concentration above 138 milli equivalents per liter of plasma. During the summer months "pure" water often must be given within thirty-six hours of the injury.

Whenever the bandages begin to loosen, water is substituted for the salt solution, for when the bandages begin to loosen, the edema of the burned part is subsiding into the blood and it will provide all the salt needed until the rate of extravasation from granulating areas exceeds the rate of subsidence of the edema. If the salt water drinking fluid is continued after the edema begins to subside, it will maintain the edema and interfere with healing.

EFFECTIVENESS

A physician should not accept the methods of treatment herein outlined without direct evidence that it is more effective than others.

The only form of treatment that would prolong the lives of dogs for three days or more when they were scalded so severely that they would die within eight to ten hours when not treated was blood intravenously and a mixture of sodium chloride and bicarbonate (about a .45 per cent solution) by mouth. All other forms of treatment such as blood by vein and water by mouth ad libitum, serum and salt water, and salt water alone were relatively ineffective (fig. 2).

Those treated with blood intravenously and water ad libitum by mouth recovered from shock but died of convulsions (water intoxication). Those treated with saline (sodium chloride and sodium bicarbonate) alone,* or saline plus serum died of shock or pulmonary congestion and edema.

Within the past two years more than 30 severely burned children and adults have been treated with whole blood, Hartmann's solution, a little plasma intravenously, and the sodium chloride-bicarbonate solution orally: No early toxemias have been seen in this series, and no anurias have occurred in the patients living longer than six hours after the injury. Comparative statistics regarding mortality and morbidity are now being collected.

Other reports on the efficacy of whole blood early and sodium chloride-bicarbonate solution by mouth are given by Abbott and others,[1, 2] McDonald, Cadman, and Scudder,[4] and Evans and Bigger.[3]

The transfusion of blood and the administration of the salt water take care of the shock and the suppression of urine and prevent water intoxication, those measures do not prevent the metabolic acidosis (ketosis) which is so prone to occur in burned or scalded children. Sugar is needed to prevent the ketosis; hard candy is satisfactory.

Potassium and calcium deficits tend to develop later, especially if the patient does not eat enough while large granulating areas exist.† Whole or dried milk is preferable to the parenteral protein products, for it provides calcium; and the native cell proteins (meat, liver, fish) are superior to the protein digests because the cell proteins provide more potassium

*A sodium chloride solution of from 0.6 to 0.9 per cent cannot be drunk in large quantity because the drinking of it is followed by nausea, vomiting, and diarrhea even in a well person. The admixture of enough sodium chloride and sodium bicarbonate or citrate in water to make a .45 to .6 per cent solution does not often induce nausea, vomiting, or diarrhea when taken orally.

*Unpublished data not shown in figure 2.

†A granulating area should be looked upon as a hole in the bucket—it leaks everything: red cells, protein, sodium, potassium, and calcium.

than the protein digests do. The protein of the diet should therefore consist largely of milk and meat.

The physiologic changes and the methods of correcting or preventing them are presented in outline form in table 1.

The danger of infection is always present following a burn or scald. This problem cannot be considered at length in this discussion. When infection does occur, it intensifies all the physiologic derangements associated with the burn and thereby makes the supportive therapy much more complicated.

OTHER APPLICATIONS

The basic supportive treatment of thermal injury may be qualitatively applied to a wide variety of diseases. Peritonitis is really a chemical burn of the peritonium.* Since the surface area of visceral and parietal peritonium is about one-half that of the skin, a generalized peritonitis may be thought of as a second-degree burn of one-half the body. Gas gangrene, necrotizing fascitis, and erysipelas induce the local sequestration of large amounts of extracellular fluid and red cells. Also, gas gangrene is associated with a fulminating destruction of red cells. Fractures of the pelvis, the shaft of the femur, and the transverse processes of lumbar vertebrae and acute thrombophlebitis are followed by large losses of extracellular fluid and blood into the afflicted area. The acute phases of the exfoliative and bullous dermatoses are associated with the same fundamental disturbances that follow burns. The collection of only 3 mm. of edema in and beneath the skin represents a functional loss of more than 5 liters of extracellular fluid in the average man.

It is obvious that the principles of the supportive treatment of thermal injury have a wide applicability.

TABLE 1.—*Stages of Thermal Injury*

Physiologic Changes	Treatment
Stage 1—Shock-edema formation phase begins with injury and ends 50 to 60 hours later	
Loss of circulating red cells and plasma proteins	No scrubbing of burned or scalded parts; it adds to initial injury and aggravates loss of red cells, etc.
	Transfusion of whole blood as soon as possible; give plasma or Hartmann's solution until blood can be obtained; give up to 3 or 4 per cent of body weight in first 24 hr. and continue on subsequent days if pulse is still high and soft
Growing edema of injured parts which induces deficit of extracellular fluid in uninjured parts of body	No water without salt in it unless signs of need for it appear (see text)
	3.0 Gm. NaCl and 1.5 Gm. $NaHCO_3$ per quart of cold water to drink; if vomited while shock exists, give Hartmann's solution intravenously; amounts must be gauged on clinical signs of adequacy or need
Danger of ketosis, especially in children	Food, especially protein (in excess of 100 Gm. per 24 hr.) and carbohydrate (in excess of 300 Gm. per 24 hr.); hard candy
Stage 2—Early recovery phase starts with subsidence of edema and ends when separation of eschar begins	
Delayed hemolysis	Transfusion of blood as required to keep hemoglobin above 10 Gm. per 100 cc.
Edema of injured parts decreasing	Stop salt water by mouth; give water ad libitum
Tissue growth beginning	Food, including milk and meat to give 200 to 400 Gm. protein daily and carbohydrate and fat to give 1,000 calories in excess of normal requirements
Stage 3—Phase of slough-separation, granulation, and epithelialization	
Loss of red cells, especially when dressings changed	Transfusion of whole blood as for stage 2
Rapid expansion of capillary vascular bed in granulating areas	Salt water intermittently as required to make up for loss in excess of sodium salts taken in food
Sodium loss through granulations	
Potassium loss through granulations while there is great demand for it by growing cells	Food as in stage 2
	Never wet dressing with boric acid; it is poison
Calcium loss through granulations	Never place patient in water; it also is "poisonous"*
Protein loss through granulations	Graft as soon as possible

*If immersion or massive wet dressings are employed to clean wounds and control infection, the wetting agent must be an isotonic saline solution (8 Gm. NaCl per liter). If water or hypotonic salt solutions are used, sodium salts are drawn into the dressings or bath water and water enters the body. These changes result in salt-lack shock combined with water intoxication. This syndrome is rapidly fatal.

WARNING

A word of warning is needed concerning the application of pressure dressings over the chest and abdomen. They are dangerous because they impede breathing, and even a little impediment to breathing in the severely injured person may be enough to kill him. Pulmonary edema, pulmonary congestion, and atelectasis are easily produced by the restriction of breathing in the injured.

The dressings covering the chest and abdomen must be loose. It is better to have a living patient with edema of the chest or abdomen than it is to have a dead one with no edema.

SUMMARY

Some of the basic physiologic derangements associated with thermal injury are discussed.

An outline of treatment based upon physiologic need is presented.

The principles of the supportive therapy of burns

*Bacterial peritonitis is really a chemical peritonitis; the damaging chemicals are made by the bacteria. Bile, pancreatic juice, and the contents of the stomach and upper intestine are powerful inflammatory chemical agents.

and scalds are qualitatively applicable to a wide variety of illnesses.

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A NEW ANTIBACTERIAL IN SURGERY

Sulfamylon-Streptomycin

W. R. WHITEHOUSE, M.D., R. W. KIMBRO, M.D., and GLENN R. WRIGHT, M.D., Cleburne, Texas

SINCE even before the development of the germ theory, surgeons have been applying to wounds a great variety of medicaments in an effort to secure a more satisfactory healing. With the early development of antibacterials, little was known regarding the physiology and pathology of wound healing; however, with improved scientific wound evaluation, we have come to know the limitations and even detriments of certain improperly used mercurials as well as other caustic preparations. The introduction of the sulfonamides, and now the antibiotics, opens an era with new possibilities for advancement in regard to antibacterials. This paper offers a new drug combination for use with adequate modern surgical handling of wounds, since at times extensive debridement may not be possible or accomplished within the most desirable time.

CHEMISTRY AND PHARMACOLOGY

Sulfamylon is a white crystalline substance (molecular weight 222.67) which is freely soluble in water and has a pH of 5.2 in the 5 per cent solution employed. The drug is not inhibited by p-aminobenzoic acid because of a methylene group in its molecule, inserted between the benzene ring and the 4-amino group, rendering it more stable. It has a high bacteriostatic potency because of sulfur in the benzene ring, giving it a protracted efficiency in the presence of blood, pus, and damaged tissues. The acetylated form of sulfamylon is readily soluble, and has a low toxicity due to the presence of nitrogen atoms. The conjunction of streptomycin and sulfamylon in no way alters the characteristics of either. Sulfamylon is rapidly deaminated, and oxidized in the body to p-carboxbenzenesulfonamide, which is rapidly and completely excreted in the urine within twenty-four hours.

With these properties in mind, it is well to review the antibacterial qualities of drugs currently used in handling wounds.

Qualities of Currently Used Drugs

Heavy Metal Group. — Adequate antibacterial agents among the heavy metal group (mercury, for example) which exhibit low cell toxicity are impossible to find since they are too toxic to cells and prevent or retard wound healing. Dilute solutions are valueless because the metabolism of the gram-negative bacilli closely resembles that of the tissue cells; to destroy one is to destroy the other. In modern surgery heavy metals find no place nearer than the edge of a wound in skin preparation.

Sulfonamides (except for sulfamylon) fail to act in the presence of pus because the crystals or powder are poorly soluble in the tissue juices available and are inhibited by the p-aminobenzoic acid always present. The drugs cause unfavorable foreign body and tissue toxicity reactions. The local application to wounds of the commonly used sulfonamide crystals or powder introduces a "foreign," imperfectly bacteriostatic element, and wound healing is unfavorably influenced.

Antibiotics.—Penicillin applied topically fails to hasten the resolution of established infection in wounds because penicillinase, which destroys penicillin, is elaborated by gram-negative bacilli, which invariably contaminate infected wounds. Gram-nega-

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tive bacilli such as Escherichia coli, Bacillus pyocyaneus, and Proteus are *not* destroyed by penicillin, and these in turn destroy penicillin. Antibiotics are highly specific in their action, having no action against certain bacteria and yet powerfully active against others. To date it has been shown that any substance which would act against both gram-positive and gram-negative organisms would likely be toxic to animal cells. It is therefore necessary to find a drug combination which will suffice until a "universally specific" drug is obtained. Antibiotics also have the property of induction of resistance upon prolonged usage; therefore, the local "high-concentration" application destroys rapidly before the bacteria become resistant.

A sulfonamide-antibiotic synergism has been observed in the handling of a large variety of infections by various authors.

Penicillin, highly unstable with environmental changes, is easily destroyed, making all local use in wounds uncertain. Applied topically in wounds, penicillin, in adequate concentration, may slightly or even markedly delay the rate of wound healing.

CLINICAL APPLICATION

We have found the following method satisfactory in using sulfamylon: From 10 to 20 cc. of a solution of sulfamylon 5 per cent and streptomycin 200 units per cubic centimeter is used to wash the wound and inject the tissues surrounding the cut surfaces, preceded by adequate debridement where possible. Fine mesh gauze is saturated with the solution and packed into unsutured wounds and surface wounds in which infection is well established. Continuous and repeated irrigation of wounds is carried out where through-and-through drainage with tubes is possible.

Types of wounds (by bacterial content) in which we have used sulfamylon and the number of cases of each are as follows: infected — perineal wounds (episiotomy) 1, abdominal 4, and "minor" wounds 51. Contaminated (incised and lacerated)—perineal wounds (episiotomy) 329, abdominal wounds 525, and "minor" wounds 705.

OBSERVATIONS OF WOUNDS

Wounds were observed for erythema and edema, serous drainage, delayed union, and nonunion. They were conspicuously free of serous drainage, which so frequently characterizes the wound to which sulfa crystals are applied.

Among the 330 perineal wounds treated (episiotomy) with the solution, including 1 grossly infected wound, primary healing was obtained throughout with no separation of tissues or conspicuous prolongation of the exudative phase.

In 4 infected wounds (ruptured appendices) primary union of the abdominal wall was obtained, while in 525 clean contaminated wounds (in 82 per cent the intestine was entered) only 2 wounds produced slight serous drainage and none showed gross infection. There was 1 instance of wound separation; however, with attention to restoration of protein and ascorbic acid levels, the resutured wound healed without infection.

The handling of 705 minor wounds was characterized by rapid primary healing of incised wounds and definite increase in speed and efficiency of healing in the lacerated wounds, as compared with any results previously obtained by us with sulfonamide or other antibiotic therapy. No burns were treated; however, the superiority of the solution over other drugs in retarding B. pyocyaneus should qualify it for such usage.

ADVANTAGES

Streptomycin and sulfamylon solution is nontoxic to fresh cells in concentrations (200 units per cubic centimeter) used, and even granulations are unaffected by solutions of 1,000 units per cubic centimeter. Exact standardization of concentration is important since granulations are less easily damaged by antibacterials than are fresh tissues. In solution used the drugs have been shown to be negligibly inhibitory to freshly cut tissue.

In the solution used, streptomycin unlike other antibiotics is bactericidal after only a short period of contact with the bacteria, while sulfamylon is superior to all other drugs within its range of action. Sulfamylon has a wider effective bacterial spectrum than penicillin although it is occasionally not as powerful. Streptomycin has a wide bacterial spectrum (80 per cent of the various bacteria are destroyed), but even this is incomplete and needs supplementation with sulfamylon. Both drugs in the combination have been shown to have a wider range of bacterial activity than any known biologically suitable antibacterial although it has been shown that the streptococcus and B. pyocyaneus are least vulnerable.

The solution acts in the presence of pus and blood.

No evidence of systemic or local drug "reactions" of any type has been observed in the concentrations used.

Topical application places greater concentrations of the drug in the wound than could be obtained by parenteral administration, a point especially important during the contaminated but still uninfected period.

CONCLUSION

Sulfamylon-streptomycin solution is superior to other available antibacterials, but is more effective in preventing infection than in shortening the resolution of established infection.

Sulfamylon-streptomycin applied topically to

wounds and injected into surrounding tissue permitted healing with minimal debridement. This is especially important in wounds where extensive and complete debridement is impossible.

In heavily contaminated operative wounds, washing with sulfamylon-streptomycin solution prevents infection and may be used in all wounds as an additional safety factor.

Even in the presence of crushed tissue prevention of infection may be obtained if the wound is treated before the contaminated tissues have time to become infected (about four hours).

With careful attention to cleansing and debridement, prevention of infection may be obtained when the solution is employed two or three days after wounding.

The combination of sulfamylon and streptomycin applied locally destroys all strains of bacteria commonly encountered in fresh wounds and exerts a stronger effect against B. pyocyaneus than any similar substances.

The routine employment of antibacterials now becomes a valuable adjunct but in no way a replacement for good surgery.

The sulfamylon-streptomycin solution employed in this clinical evaluation was supplied by the Medical Research Department of Winthrop-Stearns, Inc.

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ABSTRACT OF DISCUSSION

DR. MARTIN HOCH, Smithville: There are several facts presented by the essayists which deserve further emphasis.

Possibly the foremost fact is that topical penicillin solutions, salves, and so forth, are of no practical value and at times even detrimental to the healing of wounds. For a time we were led to believe that this antibiotic would heal almost anything; then our results proved that again we were to search for the "cure-all." Traumatic wounds treated by thorough flushing with sterile saline solution and debridement of dead tissue, careful attention being given to the blood supply of surrounding apparently uninjured tissue, gave better healing with less morbidity than those in which a mercurial, sulfanilamide, or penicillin had been used. In other words, thorough cleansing has been of more importance than the deposition into an already injured tissue of a substance which may prove detrimental to rapid resumption of normal function. It is therefore of supreme importance that a synergistic action of the available nontoxic "germ-killers" be employed.

The topical application of the solution sulfamylon-streptomycin offers a great concentration of quick acting drugs, but with a wide range of effectiveness against the most common invaders, at the time most needed, that is, during the period between contamination and actual infection. This to me is the greatest factor in favor of its employment.

The essayists have given us a new combination which is logical in its theory, simple in its application, and, according to the results reported, effective in the clinical reduction of morbidity and mortality.

PUBLIC HEALTH SERVICE TO REORGANIZE

Reorganization of the Public Health Service of the Federal Security Agency, Washington, D. C., has been approved by Surgeon General Leonard A. Scheele. Various activities of the service will be regrouped within the framework of the four previously existing bureaus so that closely related programs will be brought together in a single over-all administrative unit.

The four bureaus, in turn comprised of several divisions, are Office of the Surgeon General, Bureau of State Services, Bureau of Medical Services, and the National Institutes of Health.

Changes include the consolidation of some previously existing administrative units and the distribution of multiple functions formerly carried on by single units among several newly created divisions.

CURARE FOR RHEUMATOID SPONDYLITIS

A preparation of curare is bringing relief to persons suffering from rheumatoid spondylitis. Use of the preparation, d-tubocurarine suspended in oil and wax, is reported by Drs. Bernard M. Norcross and Harold M. Robins of the University of Buffalo Medical School, New York, in the May 28 issue of *The Journal of the American Medical Association.*

In 6 cases in which the preparation was given after other treatment usually prescribed had failed to produce improvement, the patients were relieved of pain, their muscles were relaxed, deformity of the spine was corrected, and they were able to take more exercise. Practically no toxic effects were noted, the doctors state.

GENERAL PRACTICE BRANCH FOR AIR FORCE

Initiation of a General Practice Branch in the Air Surgeon's Office, to be charged with the development of training opportunities and careers for general practitioners serving at U. S. Air Force installations, was announced recently by the air surgeon, Major General Malcolm C. Grow.

Under the new program the general practitioner will be enabled to enter into a proposed residency program to be operated in the general hospital setup. The residency program will offer the general practitioner access to latest technical developments in medical and surgical specialties. Special emphasis will be placed on internal medicine, surgical practice, pediatrics, and obstetrics.

DIAPHRAGMATIC HERNIA FROM A ROENTGENOLOGIC VIEWPOINT

B. R. KIRKLIN, M.D., Section on Radiology,
Mayo Clinic, Rochester, Minnesota

UNTIL scarcely more than twenty years ago diaphragmatic hernia was regarded as a rare affection, so rare that almost every individual case discovered was deemed worthy of special report. Since then, however, appropriate roentgenologic examination has shown that if all small, reducible and symptomless hernias are included, diaphragmatic hernia is a common internal lesion, so common that it should be kept constantly in mind by every general practitioner, internist, and roentgenologist.

The morbid anatomy, which of course determines the roentgenologic manifestations of diaphragmatic hernia, is not simple. The abdominal viscera implicated in the extrusion into the thoracic cavity through the breach in the diaphragm may be the stomach, large or small bowel, liver, spleen, or omentum, singly or in varying combinations. Like other hernias the diaphragmatic variety may be congenital or acquired, large or small, reducible and inconstant, or incarcerated and constant. By far the greater number of herniations are through the left half of the diaphragm, but exceptionally the right half, though protected by the right lobe of the liver, is penetrated. Most often the site of the breach is a hiatus or other foramen for the passage of the esophagus or blood vessels between the thorax and the abdomen, or a deficiency or weak spot at the junction of embryonic segments. Thus either most of the hernias are congenital or a congenital factor contributes to their production. However, the proximal cause of most hernias is the imbalance between the intrathoracic and the intra-abdominal pressure or an abnormal increase of the latter so that most hernias are in some degree acquired. To these etiologic factors must be added perforations of the diaphragm by localized disease or penetrating wounds, or its rupture by extreme increase of the intra-abdominal pressure through crushing injury or violent forward flexion of the body.

In view of this complexity it is not surprising that many classifications of hernia have been offered. I consider the one proposed by Harrington[1] to be most satisfactory, for it is complete and can be applied advantageously by clinicians, roentgenologists, and surgeons alike. Especially significant from the roentgenologic viewpoint in Harrington's classification are the following types of diaphragmatic hernia:

1. Hernias through the esophageal hiatus. Of this form there are four varieties.
   a. Congenitally short esophagus with true thoracic stomach.
   b. Esophageal hiatal hernia with acquired shortening of the esophagus.
   c. Esophageal hiatal hernia without shortening of the esophagus.
   d. Para-esophageal hernia through the hiatus.
2. Hernia through the foramen of Morgagni.
3. Pleuroperitoneal hernia.
4. Hernia through congenital defects in the diaphragm.
5. Congenital absence of the hemidiaphragm.
6. Posttraumatic hernia.

DIAGNOSIS

The clinical manifestations of diaphragmatic hernia vary in character and intensity with its magnitude and the degree of interference with the functions of the abdominal viscera herniated and of the thoracic organs compressed or displaced. Many small reducible hernias are symptomless. When symptoms are present, pain is the most common manifestation. Obviously, large hernias may cause dyspnea. Other symptoms, referable chiefly to the alimentary canal, include dysphagia, bloating, nausea, and vomiting. Thoracic physical signs are often marked but not definitive. Occasionally in cases of traumatic hernia the patient will give a history of violent flexion of his body or crushing injury of his abdomen that is suggestive. In general, however, neither symptoms nor signs are more indicative of diaphragmatic hernia than of other internal disorders, but they should at least be regarded as signals for roentgenologic examination of the thorax or alimentary canal or both. Only by such examination can the presence of diaphragmatic hernia be determined or excluded definitely.

Often unreduced hernias are first disclosed in roentgenograms of the thorax as abnormal shadows at the base of the lungs. If the alimentary canal is implicated, the gas bubble of the stomach or the typical markings of the intestines may be identifiable in their unwonted supradiaphragmatic situation. Far more often, however, the hernias of stomach or bowel, many of them small and their existence un-

Read before a general meeting, State Medical Association of Texas, Annual Session, San Antonio, May 5, 1949.

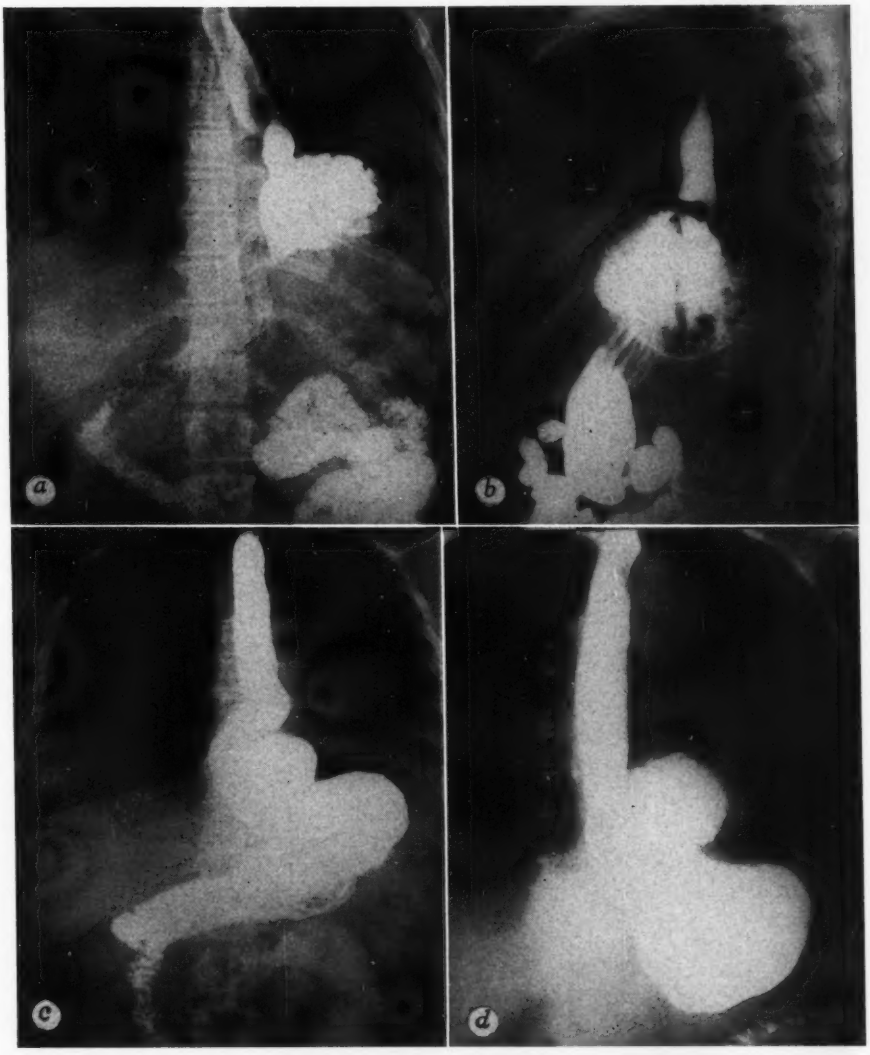

FIG. 1a and b. Congenitally short esophagus. *a*. A large part of the stomach is shown above the diaphragm. *b*. Lateral view of the thorax. At operation the hiatus was extremely large (12 cm.) and the hernia contained five-sixths of the stomach, a loop of transverse colon, and a portion of the spleen. [All figures reproduced by permission of Charles C. Thomas, publisher, after Kirklin, B. R., and Hodgson, J. R.: Roentgenologic Characteristics of Diaphragmatic Hernia, Am. J. Roentgenol. *58*:77-101 (July) 1947.]

c. Esophageal hiatal hernia with slight redundancy of the lower end of the esophagus.

d. Para-esophageal hernia at the esophageal hiatus. The cardial end of the stomach has herniated through the esophageal hiatus, but the esophagogastric junction is below the diaphragm.

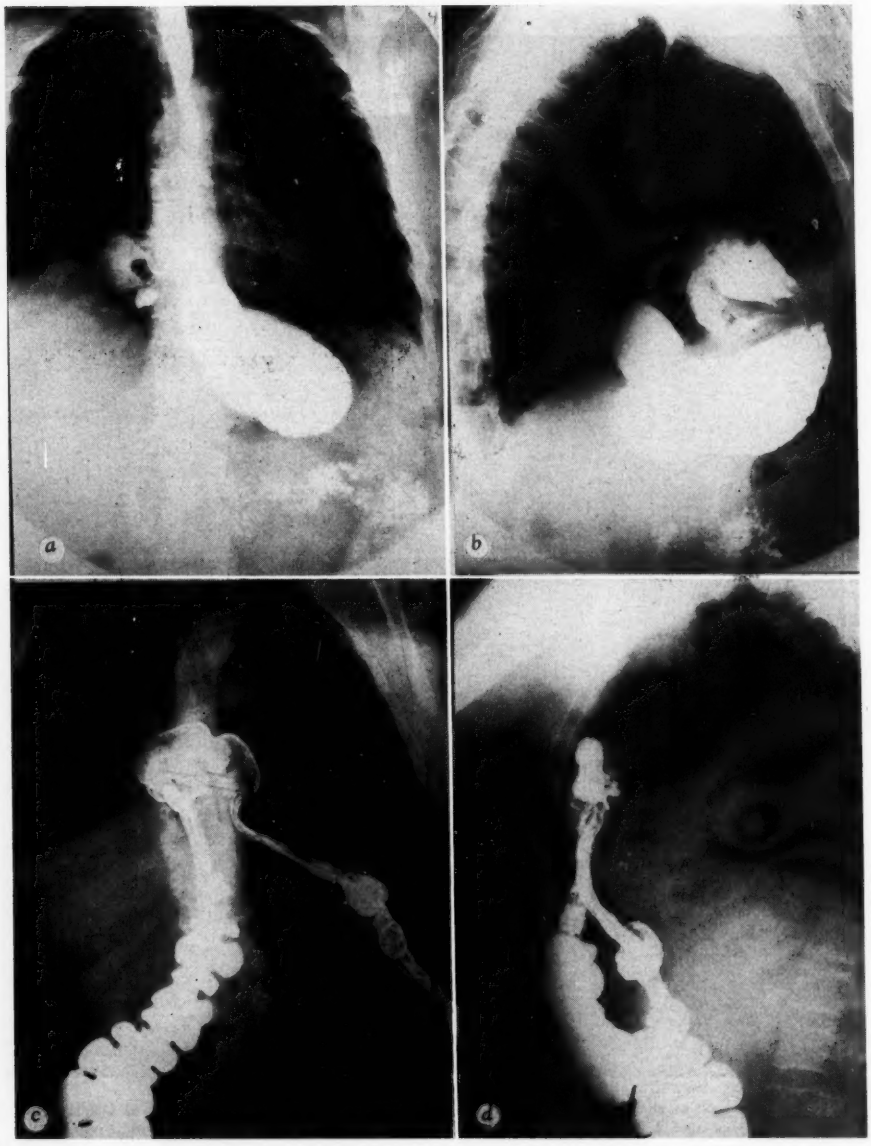

FIG. 2. Bilateral foramen of Morgagni hernias. *a*. The pyloric end of the stomach in the right-sided hernia. There is also a small esophageal hiatal hernia. *b*. Lateral view. *c*. The colon in a left-sided foramen of Morgagni hernia. *d*. Lateral view.

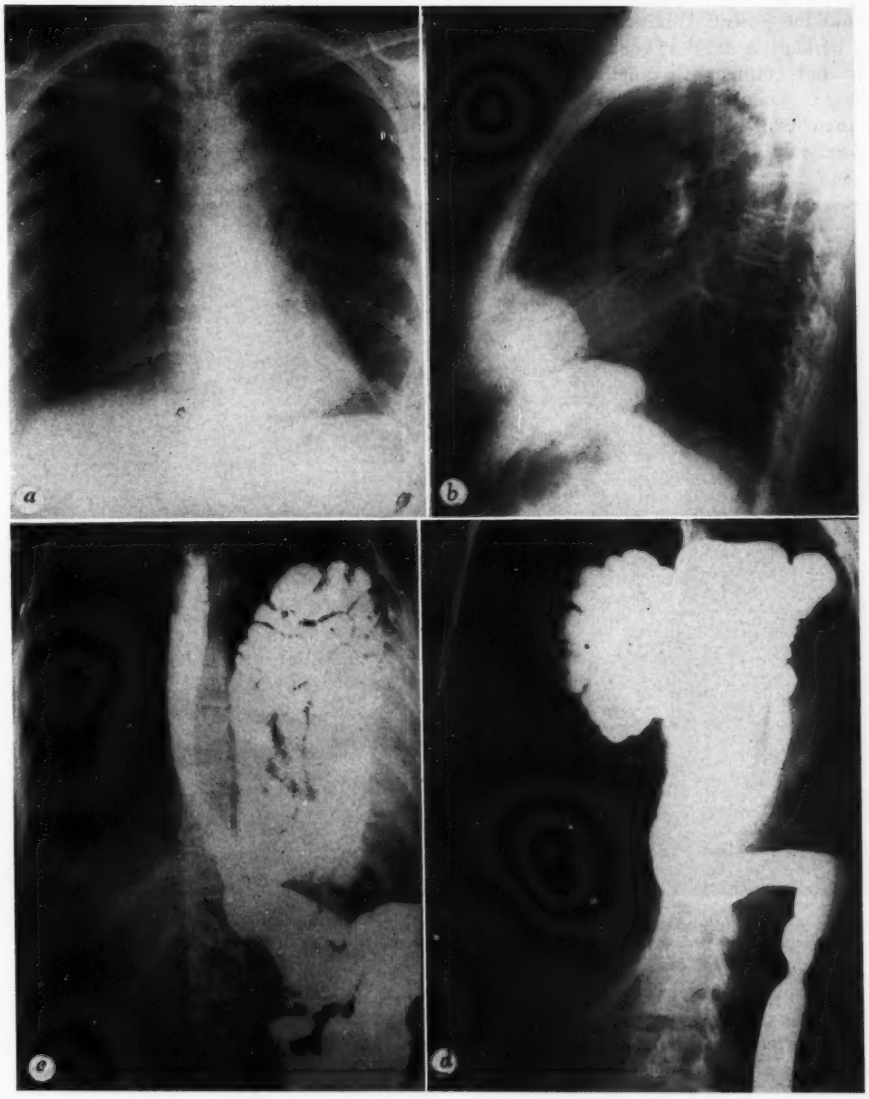

FIG. 3a and b. Foramen of Morgagni hernia in the case of a woman, aged 51 years, who had no symptoms referable to this lesion; at operation she was found to have a foramen of Morgagni hernia containing omentum. *a*. Note the triangular shadow in the cardiophrenic angle on the right side. *b*. Lateral view of the thorax. Note the dense shadow anteriorly.

c and d. Pleuroperitoneal hernia. *c*. A large amount of small bowel above the diaphragm. At operation it was found that the pleuroperitoneal membrane had completely failed to develop. The stomach is in a normal position below the diaphragm. *d*. Oblique view; transverse colon, ascending colon, and loops of small intestine above the diaphragm.

suspected, are reduced and demonstrable only with the usual suspension of barium.

In the main, both the revelation and the diagnosis of diaphragmatic hernia are essentially roentgenologic problems, and the potential existence of that affection should be kept in mind at every examination of the thorax and alimentary canal. In beginning roentgenoscopic examination of the stomach the course of the first swallows of barium should be observed closely. If the lower end of the esophagus is tortuous or displaced toward the patient's right in a sweeping curve or if the entrance of the barium into the stomach is retarded, hernia should be considered. To reproduce a hernia that has been reduced spontaneously, the intra-abdominal tension should be increased by manual pressure or by requiring the patient to tense his abdominal muscles. If those maneuvers fail while the patient is standing and doubt still remains, they may be repeated with the patient recumbent. Implication of the small bowel can be confirmed or excluded by following the progress of the barium mixture, and examination with the barium enema will readily determine whether the colon is involved. In any case the distinctive and unimpeachable mark of diaphragmatic hernia is the supradiaphragmatic situation of the extruded viscus; hence the thin curvilinear shadow of the diaphragm should be traced to the margin of the breach if possible. Many of the signs that contribute to the total picture will vary among the different varieties of the hernia.

TYPES OF HERNIA

The congenitally short esophagus with thoracic stomach is, strictly speaking, not a true hernia, since the thoracic portion of the stomach has never been below the diaphragm but in the process of development either has failed to migrate caudad or has been held up by failure of the esophagus to lengthen normally. The roentgenologic appearance needs no description since it corresponds to the morbid anatomy (fig. 1a and b).

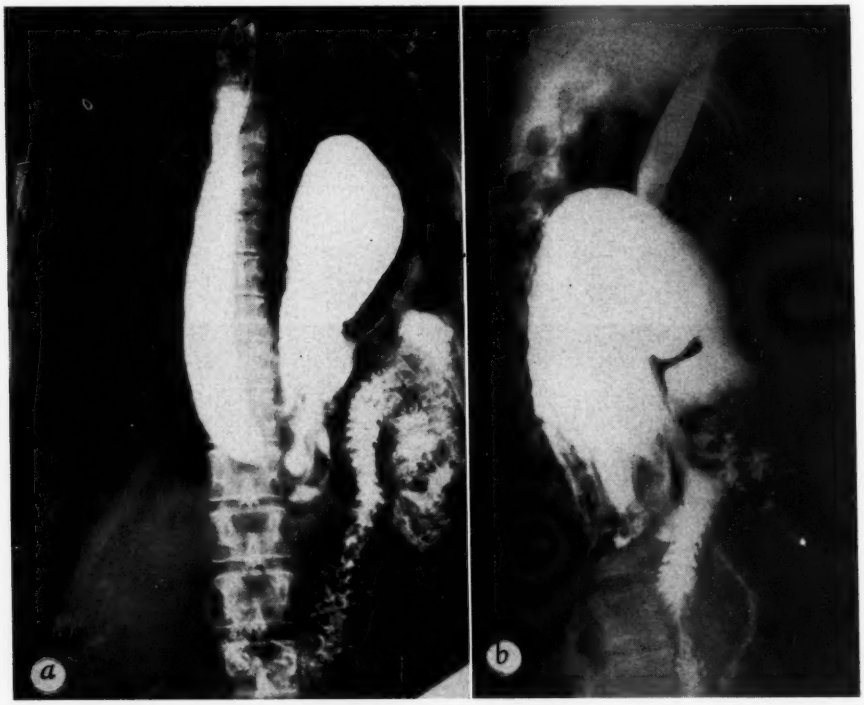

FIG. 4. Congenital absence of the posterior half of the diaphragm on the left. *a*. The stomach and a portion of the small bowel in the left side of the thorax. *b*. Lateral view. The hernia contained stomach, colon, and small bowel.

Esophageal hiatal hernia with shortened esophagus is common and, in my experience, constitutes more than one-fourth of the hiatal hernias. It is a true hernia and the shortening of the esophagus is due to contraction after the stomach has herniated. At operation the shortened esophagus can sometimes be stretched considerably. Thus in determining whether to operate or not, the surgeon would appreciate pre-

operative roentgenologic distinction of this from the preceding type. Unfortunately the roentgenologist cannot accurately identify the thoracic stomach, although he may reasonably incline to this diagnosis if the esophagus is extraordinarily short, whereas if the shortening is slight or moderate, the presumption is strong that it is associated with a true hernia.

Esophageal hiatal hernia without shortening of the esophagus is the most common of the hiatal hernias, accounting for more than two-thirds of them. Pathologically and roentgenologically this form has two characteristics: the juncture of the esophagus with the stomach is above the diaphragm, and the lower end of the esophagus is more or less redundant and tortuous (fig. 1c).

FIG 5. Inflammatory necrosis of the diaphragm with diaphragmatic hernia in the case of a girl, aged 15 years, who had a ruptured appendix with generalized peritonitis followed by empyema. At operation inflammatory necrosis of the diaphragm was found with three large openings, which measured from 4 to 9 cm. in diameter, and through which the abdominal viscera had herniated.

Para-esophageal hernia through the hiatus is not common. In this variety a portion of the stomach, usually of the cardia, is herniated through the hiatus, but the esophageal opening remains below the diaphragm and the esophagus does not participate in the hernia. All these characteristics are roentgenoscopically demonstrable (fig. 1d.)

Hernia through the foramen of Morgagni or parasternal or costosternal hernia is rare. The so-called foramen is a bilateral muscle-free triangular region of the diaphragm behind the sternum, and the hernias may be either unilateral or bilateral. Most often the hernial sac contains a portion of the colon which may be identifiable by its haustral markings, by contained gas or fluid, or only by administration of a bariumized meal or enema (fig. 2). Parasternal hernias with other contents are easily mistaken for various pulmonary lesions at the base, and if only omentum is extruded, the shadow is likely to be attributed to a new growth (fig. 3a and b).

Pleuroperitoneal hernia or hernia through the foramen of Bochdalek is an extrusion through a weak point of fusion in the membranous diaphragm posteriorly and is present at birth. It is estimated that three-fourths of the infants with this hernia die in the first month of life if not treated, but several cases in which the patient was adult have been reported. The colon, small bowel, spleen, and stomach are most often implicated (fig. 3c and d). Pronounced respiratory symptoms should lead to roentgenologic examination and early diagnosis.

Hernia through congenital defects other than those previously mentioned may occur. The herniation is more often through the left than through the right half of the diaphragm (fig. 4). Rarely, complete absence of a hemidiaphragm, commonly the left, is encountered. As a rule the congenital hernias are first revealed in roentgenograms of the thorax, and this examination applied as a routine to all infants having cardiac or respiratory embarrassment would probably save the lives of many by leading to timely surgical intervention. Complete absence of a hemidiaphragm should be distinguished from eventration. As the former is not an operable condition its distinction from a true hernia is especially important.

Posttraumatic hernias comprise those that follow penetrating wounds of the diaphragm or its rupture by crushing injury or violent compression of the abdomen by extreme forward flexion of the body. For convenience, hernias that follow localized necrosis of the diaphragm, as from subdiaphragmatic abscess, may be included in the group (fig. 5). In this group as a whole the site of herniation may be anywhere in the diaphragm but most often it is in the dome or posterior portion of the left half, and portions of any of the abdominal organs may be extruded. Occasionally, posttraumatic hernias are so massive that their roentgenologic appearance is almost spectacular (fig. 6).

The few simulants that occasionally have to be taken into account in the differential diagnosis of diaphragmatic hernia have already been mentioned. Since the stomach or bowel participates in the hernia in a great majority of cases, the roentgenoscopic exhibition of either viscus above the diaphragm is decisively diagnostic without any consideration of alter-

natives. To be sure, there is occasionally difficulty in tracing the curve or course of the diaphragm, particularly if the hernial breach is extensive. This applies also to eventration, although in this condition the fluid level of the barium mixture in the stomach is at the level of the esophageal opening but is often higher than the latter in cases of hernia involving the stomach. Further, when the hernial mass consists only of liver, spleen, or omentum, its shadow cannot be distinguished from that of a neoplasm or other lesion at the base of the lungs. On the whole, however, granting these and perhaps other actual or theoretical exceptions, roentgenologic examination will identify diaphragmatic hernias almost as consistently as it will reveal their presence.

REFERENCE

1. Harrington, S. W.: Diagnosis and Treatment of Various Types of Diaphragmatic Hernia, Am. J. Surg. *50*:381-446 (Nov.) 1940.

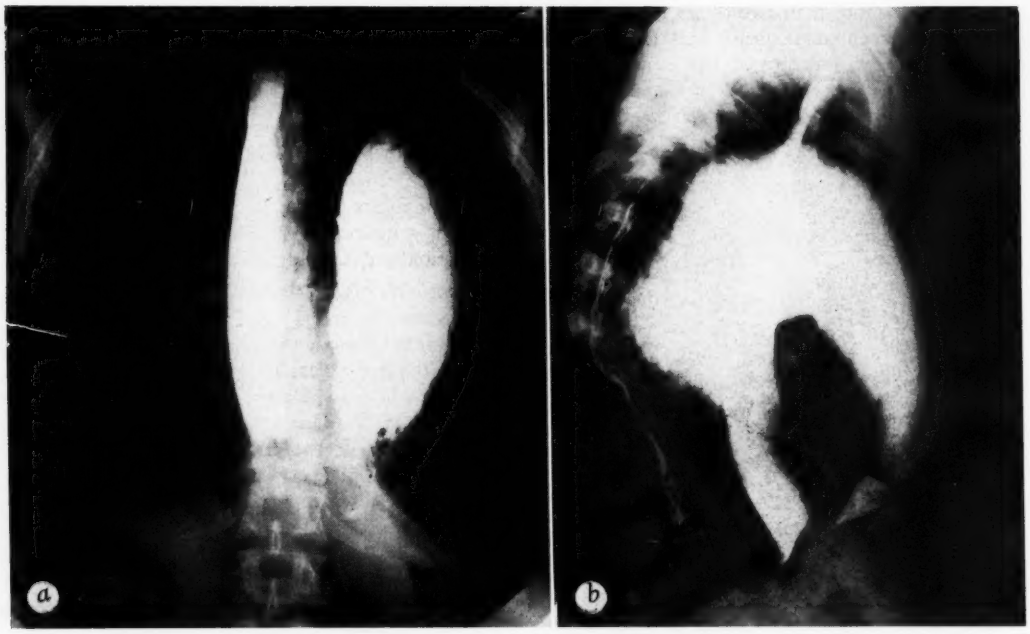

FIG. 6. Posttraumatic diaphragmatic hernia. *a*. The stomach and colon in the left side of the thorax. Three years before operation the patient had been in an automobile accident, in which he was "jack-knifed" under a car. At operation the diaphragm was found to be torn from one half of the thoracic wall posteriorly, and stomach, colon, spleen, small bowel, and left kidney were found within the left side of the thorax. *b*. Lateral view of the stomach.

Handbook on Medical X-Ray Protection

Recommended standards of safety for the installation and use of high-voltage x-ray equipment are concisely set forth in "Medical X-Ray Protection up to Two Million Volts," published by the National Bureau of Standards as Handbook 41, and obtainable for 15 cents from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

In the handbook are given rules for working conditions, survey and inspection of installations, planning an x-ray installation, structural details of protective barriers, and specific types of installations. A chapter on electrical protection treats such topics as high-voltage circuits, grounding inspection and maintenance, warnings and instructions, and first-aid and fire-extinguishing devices. Also included are tables and graphs for determining the requirements of protective barriers and distance protection in specific cases.

STERILITY OF EARLY CONCERN

An investigation into the reasons for a childless marriage should be started a year after a planned pregnancy, state three Baltimore physicians in the August 20 *Journal of the American Medical Association*. It has been customary to show little interest in the reproductive disappointments of a couple until sterility has continued for at least two years.

Drs. Alan F. Guttmacher and Samuel Rubin of the Johns Hopkins University School of Medicine and of the Sinai Hospital, and Dr. Christopher Tietze of the National Committee on Maternal Health, Inc., based their recommendations on a study of contraception among 2,000 private obstetric patients.

"Three-fifths of the planned pregnancies occurred within three months, and more than nine-tenths within one year from the time contraception was discontinued. To us this seems decidedly significant. It might furnish the obstetrician and gynecologist grounds to pause and consider."

NEWS

COMING MEETINGS AND CLINICS

State Medical Association of Texas, Fort Worth, May 2-4, 1950. Dr. G. V. Brindley, Temple, Pres.; Dr. Harold M. Williams, 700 Guadalupe St., Austin, Secy.

American Medical Association, Clinical Session, Washington, D. C., Dec. 6-9, 1949. Dr. Ernest E. Irons, Chicago, Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy. Dr. Will C. Sprain, New York, Pres.; Dr. Theodore L. Squier, 424 E. Wisconsin Ave., Milwaukee, Secy.

American Academy of Dermatology and Syphilology. Dr. Francis E. Senear, Chicago, Pres.; Dr. Earle D. Osborne, 471 Delaware Ave., Buffalo, N. Y., Secy.

American Academy of General Practice, St. Louis, Feb. 20-23, 1950. Dr. Elmer C. Texter, Detroit, Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Neurological Surgery. Dr. William S. Keith, Toronto, Canada, Pres.; Dr. T. C. Erickson, 1300 University Ave., Madison 5, Wis., Secy.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 9-14, 1949. Dr. Conrad Berens, New York, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, San Francisco, Nov. 14-17, 1949. Dr. Warren R. Sission, Boston, Pres.; Dr. C. G. Grulee, 636 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Denver, Colo., April 15-19, 1950. Dr. Edward J. O'Brien, Detroit, Pres.; Dr. Brian Blades, 901 23rd. St. N. W., Washington, D. C., Secy.

American Association of Genito-Urinary Surgeons, Hershey, Pa., May 26-28, 1950. Dr. J. A. C. Colston, Baltimore, Pres.; Dr. Norris J. Heckel, 122 S. Michigan Ave., Chicago 3, Secy.

American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, Hot Springs, Va., Sept. 8-10, 1949. Dr. James R. Bloss, Huntington, W. Va., Pres.; Dr. L. A. Calkins, University of Kansas Medical Center, Kansas City 3, Secy.

American Cancer Society. Dr. Clifford C. Nesselrode, Kansas City, Kan., Pres.; Mr. Charles D. Hilles, 47 Beaver St., New York, Secy.

American College of Physicians, Boston, April 17-21, 1950. Dr. Reginald Fitz, Boston, Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, San Francisco, Jan. 25, 1950. Dr. Arthur W. Erskine, Cedar Rapids, Iowa, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Secy.

American College of Surgeons, Chicago, Oct. 17-21, 1949. Dr. Dallas B. Phemister, Chicago, Pres.; Dr. Paul B. Magnuson, 40 E. Erie St., Chicago 11, Secy.

American Congress of Physical Medicine, Cincinnati, Sept. 6-10, 1949. Dr. O. Leonard Huddleston, Vallejo, Calif., Pres.; Dr. Richard Kovacs, 2 E. 88th St., New York 28, Secy.

American Dermatological Association, Jasper National Park, Canada, June 18-22, 1950. Dr. Charles C. Dennie, Kansas City, Pres.; Dr. L. A. Brunsting, 102 2nd Ave., S. W., Rochester, Minn., Secy.

American Gastro-Enterological Association, Atlantic City, April 28-29, 1950. Dr. J. Arnold Bargen, Rochester, Minn., Pres.; Dr. Dwight L. Wilbur, 655 Sutter St., San Francisco, Secy.

American Gynecological Society, White Sulphur Springs, W. Va., May 11-13, 1950. Dr. Joseph L. Baer, Chicago, Pres.; Dr. Norman F. Miller, Ann Arbor, Secy.

American Hospital Association, Cleveland, Sept. 26-29, 1949. Mr. Joseph G. Norby, Milwaukee, Pres.; Mr. George P. Bugbee, 18 E. Division St., Chicago, Executive Secy.

American Laryngological, Rhinological, and Otological Society, San Francisco, May 25-27, 1950. Dr. Robert C. Martin, San Francisco, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Atlantic City, June 12-14, 1950. Dr. Henry W. Woltman, Rochester, Minn., Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, Hot Springs, Va., May 31-June 2, 1950. Dr. Parker Heath, Boston, Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, Virginia Beach, Va., May, 1950. Dr. R. W. Johnson, Jr., Baltimore, Pres.; Dr. C. Leslie Mitchell, Henry Ford Hospital, Detroit 2, Secy.

American Pediatric Society, French Lick, Ind., May 8-10, 1950. Dr. Phillip C. Jeans, Iowa City, Pres.; Dr. Henry G. Poncher, 1819 W. Polk St., Chicago 12, Secy.

American Proctologic Society. Dr. Louis E. Moon, Omaha, Pres.; Dr. W. Wendell Green, 1838 Parkwood Ave., Toledo 2, Secy.

American Psychiatric Association, Detroit, May 1-5, 1950. Dr. George S. Stevenson, New York, Pres.; Dr. Leo H. Bartemeier, General Motors Bldg., Detroit, Secy.

American Public Health Association, New York, Oct. 24-28, 1949. Dr. Charles F. Wilinsky, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Secy.

American Society of Anesthesiologists, New York, Dec. 7-10, 1949. Dr. H. Boyd Stewart, Tulsa, Okla., Pres.; Dr. Curtis B. Hickcox, 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists, Chicago, Oct. 11-15, 1949. Dr. Osborne A. Brines, Detroit, Pres.; Dr. Clyde G. Culbertson, Indiana University School of Medicine, Indianapolis, Secy.

American Surgical Association, Colorado Springs, April 19-23, 1950. Dr. Thomas Orr, Kansas City, Kan., Pres.; Dr. Nathan Womack, University of Iowa, Iowa City, Secy.

American Urological Association, Washington, D. C., May 29-June 1, 1950. Dr. Carl F. Rusche, Hollywood, Calif., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

International College of Surgeons, U. S. Chapter, Atlantic City, Nov. 7-12, 1949. Dr. Curtis L. Hall, Washington, D. C., Pres.; Dr. Arnold S. Jackson, 16 S. Henry St., Madison, Wis., Secy.

National Tuberculosis Association, Washington, D. C., April 25-28, 1950. Dr. R. D. Thompson, La Vina, Calif., Pres.; Dr. H. Stuart Willis, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Cleveland, Dec. 4-9, 1949. Dr. Edgar P. McNamee, Cleveland, Pres.; Dr. D. S. Childs, Medical Arts Bldg., Syracuse 2, N. Y., Secy.

Southern Medical Association, Cincinnati, Nov. 14-19, 1949. Dr. Oscar B. Hunter, Washington, D. C., Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham, Ala., Secy.

Southern Psychiatric Association, New Orleans, Nov. 27-29, 1949. Dr. Walter J. Otis, New Orleans, Pres.; Dr. Newdigate M. Owensby, Medical Arts Bldg., Atlanta, Ga., Secy.

Southern Surgical Association, Hot Springs, Va., Dec. 6-8, 1949. Dr. Alfred Blalock, Baltimore, Pres.; Dr. John C. Burch, 2112 West End Ave., Nashville, Tenn., Secy.

Southwest Allergy Forum, Memphis, Tenn., April, 1950. Dr. L. O. Dutton, El Paso, Pres.; Dr. Sam Sanders, 1089 Madison Ave., Memphis, Tenn., Secy.

Southwest Regional Cancer Conference, Fort Worth, Nov. 9, 1949. Secy., 209 Medical Arts Bldg., Fort Worth.

Southwestern Medical Association, Albuquerque, N. Mex., Nov. 9-12, 1949. Dr. Joseph M. Greer, Phoenix, Ariz., Pres.; Dr. Wickliffe R. Curtis, First National Bank Bldg., El Paso, Secy.

Southwestern Surgical Congress, Houston, September 26-28, 1949. Dr. Walter G. Stuck, San Antonio, Pres.; Dr. C. R. Rountree, 210 Plaza Court, Oklahoma City 3, Secy.

United States-Mexico Border Public Health Association, Chihuahua, 1950. Dr. George W. Cox, Austin, Pres.; Dr. M. F. Haralson, 314 U. S. Court House, El Paso, Secy.

STATE

Texas Academy of General Practice. Dr. H. T. Jackson, Fort Worth, Pres.; Dr. W. P. Higgins, Jr., Medical Arts Bldg., Fort Worth, Secy.

Texas Air-Medics Association, Fort Worth, 1950. Dr. C. Hansford Brownlee, Austin, Pres.; Dr. C. F. Miller, 906 Medical Arts Bldg., Waco, Secy.

Texas Association of Obstetricians and Gynecologists, Dallas, Sept. 23-24, 1949. Dr. Julius McIver, Dallas, Pres.; Dr. George F. Adam, 4115 Fannin, Houston, Secy.

Texas Chapter, American College of Chest Physicians, Fort Worth, May 1, 1950. Jesse B. White, Amarillo, Pres.; Dr. Henry R. Hoskins, 514 Medical Arts Bldg., San Antonio, Secy.

Texas Club of Internists. Dr. W. Shelton Barcus, Fort Worth, Pres.; Dr. Victor E. Schulze, 219 S. Magdalen St., San Angelo, Secy.

Texas Dermatological Society. Dr. A. G. Schoch, Dallas, Pres.; Dr. W. Harris Connor, 601 Medical Arts Bldg., Houston, Secy.

Texas Diabetes Association, Fort Worth, April 30, 1950. Dr. J. Shirley Sweeney, Gainesville, Pres.; Dr. W. N. Powell, W. Ave. F, Temple, Secy.

Texas Division, American Cancer Society, Fort Worth, Nov., 1949. Mr. Frank C. Smith, Houston, Pres.; Mrs. Jack Hutchins, El Campo, Secy.

Texas Heart Association, Fort Worth, May 1, 1950. Dr. Merritt B. Whitten, Dallas, Pres.; Miss Roberta Miller, Medical Arts Bldg., Dallas, Executive Secy.

Texas Hospital Association, Galveston, March 7-9, 1950. Mr. Julian H. Pace, Waco, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association, Fort Worth, May 1, 1950. Dr. A. T. Hanretta, Austin, Pres.; Dr. David Wade, 510 Capital National Bank Bldg., Austin, Secy.

Texas Orthopedic Association, Fort Worth, May 1, 1950. Dr. Bruce Stephenson, Beaumont, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, San Antonio, Oct. 7-8, 1949. Dr. John Glen, Houston, Pres.; Dr. James Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Public Health Association, Galveston, Feb. 21-24, 1950. Dr. W. R. Ross, Tyler, Pres.; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Executive Secy.

Texas Radiological Society, Dallas, Feb. 3-4, 1950. Dr. J. J. Faust, Tyler, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association. Dr. Joe Gandy, Houston, Pres.; Dr. W. F. Parsons, First National Bank Bldg., Fort Worth, Secy.

Texas Rheumatism Association, Fort Worth, May 1, 1950. Dr. Howard C. Coggeshall, Dallas, Pres.; Dr. Robert H. Mitchell, 210 Medical Arts Bldg., Fort Worth, Secy.

Texas Society for Mental Hygiene, Mineral Wells, April 13-14, 1950. Dr. Arthur Schwenkenberg, Dallas, Pres.; Mrs. Elizabeth F. Gardner, 1617 Watchhill Road, Austin 21, Executive Secy.

Texas Society of Anesthesiologists, Fort Worth, May 1, 1950. Dr. Wilbur F. Robertson, San Antonio, Pres.; Dr. H. C. Slocum, 928 Strand, Galveston, Secy.

Texas Society of Gastroenterologists and Proctologists, Fort Worth, May 1, 1950. Dr. G. E. Brereton, Dallas, Pres.; Dr. John S. Bagwell, Medical Arts Bldg., Dallas, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 2-3, 1949. Dr. August J. Streit, Amarillo, Pres.; Dr. John L. Matthews, 929 Nix Professional Bldg., San Antonio, Secy.

Texas Society of Pathologists. Dr. John F. Pilcher, Corpus Christi, Pres.; Dr. A. O. Severance, 205 Camden, San Antonio, Secy.

Texas Surgical Society, Austin, Oct. 3-4, 1949. Dr. E. P. Bunkley, Stamford, Pres.; Dr. Truman G. Blocker, 927 Strand, Galveston, Secy.

Texas Tuberculosis Association, Austin, April 21-22, 1950. Dr. Elliott Mendenhall, Dallas, Pres.; Miss Pansy Nichols, 208 E. Ninth, Austin, Executive Secy.

Texas Urological Society, Houston, Nov. 28, 1949. Dr. Charles Simpson, Temple, Pres.; Dr. Tryon Robinson, 920 Westheimer, Houston 6, Secy.

DISTRICT

Second District Society. Dr. Charles E. Britt, Midland, Pres.; Dr. Robert M. Golladay, 1203 W Wall St., Midland, Secy.

Third District Society, Lubbock, Oct. 4-5, 1949. Dr. C. B. Jones, Wellington, Pres.; Dr. Roy G. Loveless, 2609 Nineteenth St., Lubbock, Secy.

Fourth District Society, San Angelo, Nov. 3, 1949. Dr. J. C. Young, Coleman, Pres.; Dr. Gordon F. Madding, 111 E. Harris Ave., San Angelo, Secy.

Fifth and Sixth Districts Society. Dr. Franklin W. Yeager, Corpus Christi, Pres.; Dr. Foy Moody, 1611 Fifth St., Corpus Christi, Secy.

Seventh District Society. Dr. David Wade, Austin, Pres.; Dr. Joe W. Bailey, 1411 San Antonio St., Austin, Secy.

Eighth District Medical Society. Dr. Leonard Johnson, El Campo, Pres.; Dr. Robert Casey, Texas City, Secy.

Tenth District Medical Society. Dr. J. A. Richardson, Sr., Jasper, Pres.; Dr. Dale H. Davies, Liberty, Secy.

Eleventh District Society. Dr. Lynn Hilbun, Henderson, Pres.; Dr. C. B. Young, 929 S. Confederate, Tyler, Secy.

Twelfth District Society. Dr. J. C. Terrell, Stephenville, Pres.; Dr. H. F. Connally, Jr., Amicable Bldg., Waco, Secy.

Thirteenth District Society. Dr. Porter Brown, Fort Worth, Pres.; Dr. S. W. Wilson, Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society. Dr. J. Shirley Sweeney, Gainesville, Pres.; Dr. L. W. Johnson, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Longview, October 25, 1949. Dr. P. A. Reitz, Pittsburg, Pres.; Dr. James E. Ball, Mount Pleasant, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 13-16, 1950. Miss Betty Elmer, Medical Arts Bldg., Dallas 1, Executive Secy.

International Post-Graduate Medical Assembly of Southwest Texas, San Antonio, Jan. 24-26, 1950. Dr. John J. Hinchey, 643 Moore Bldg., San Antonio 5, Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 6-9, 1950. Dr. Woodard D. Beacham, Room 105, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference, Wichita Falls, Oct. 19, 1949. Dr. James T. Lee, Wichita Falls Clinic Hospital, Wichita Falls, Program Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 24-27, 1949. Muriel R. Waller, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Post Graduate Medical Assembly of South Texas, Houston, Nov. 29-Dec. 1, 1949. Dr. E. Trowbridge Wolf, 229 Medical Arts Bldg., Houston, Secy.

Postgraduate Courses of Dallas Southern Clinical Society

Four postgraduate courses for the autumn and winter months have been arranged by the Dallas Southern Clinical Society in cooperation with the organized specialty groups and Southwestern Medical School of the University of Texas. The courses are as follows:

General Surgery, September 21-23. The honor guest will be Dr. Robert M. Moore, professor of surgery at the University of Texas Medical Branch, Galveston.

Recent Advances in Diagnosis and Therapy, October 10-13. Dr. William A. Sodeman, professor of preventive medicine, Tulane University, New Orleans, will be honor guest.

Cardiology, November 28-December 1. The honor guest will be Dr. Myron Prinzmetal, director of research, Mt. Zion Hospital, San Francisco, and University of Southern California, Los Angeles.

Obstetrics and Gynecology, January 9-11. Designed primarily to demonstrate the practical application of procedures and therapy in obstetrics and gynecology, the course will be under the chairmanship of Dr. William F. Guerriero, Dallas.

Registration for these courses is limited, and teaching is designed to appeal to specialists and general practitioners alike. In addition to the distinguished honor guests, Texas physicians and scientists in related fields will contribute to the instruction.

The registration fee for each course is $25. Application for registration may be sent to the Society, 433 Medical Arts Building, Dallas 1. Hotel reservations should be made directly with the hotels.

SUBJECT FOR SCHERING AWARD ANNOUNCED

"The Metabolic Effects of the Steroid Hormones" will serve as the subject for the 1949 Schering Award.

Held annually, the competition is conducted by the Schering Corporation, Bloomfield, N. J., for students in the medical schools of the United States and Canada, who may enter the competition by preparing manuscripts on a designated subject in the field of endocrinology. This year the cash prize awards will total $1,800.

Anderson Hospital Receives Gift

The M. D. Anderson Hospital, Houston, has received a gift of more than $250,000 through the will of the late William Heuermann, San Patricio County farmer and stockman, states the Dallas *News.* The will also provided for a fund of $5,000 to buy radium to be used in cancer treatment in Corpus Christi.

UNITED MEDICAL ADMINISTRATION

Hoover Commission Recommendation

The reorganization of federal medical activities as proposed by the Hoover Commission on Organization of the Executive Branch of the Government would provide extensive consolidation and unification of agencies in an effort to eliminate overlap, waste, and inefficiency.

The twelve-man bipartisan Commission created by Congress in July, 1947, listed among the necessary objectives of federal medical activities the providing of better medical care for beneficiaries of the program, creating a better foundation for training and medical service in federal agencies, reducing the drain of doctors away from private practice, providing better organization for medical research, and promoting a better state of medical preparedness.

The proposed United Medical Administration would include the government's major services in the field of medical care, public health, and medical research. The Administrator of the United Medical Administration would be assisted in policy-forming by an advisory board consisting of the Surgeons General of the Army and Navy, the Air Surgeon, and the Administrator of Veterans' Affairs.

The Administrator and three assistants would be appointed by the President with the advice and consent of the Senate; all other assistants would be appointed by the Administrator.

The Commission recommended for transfer to the United Medical Administration the functions, facilities, and personnel for medical care included in the following activities: general and station hospitals of the armed forces within the United States except a medical center for each of the three services and those at outlying locations which could not otherwise be conveniently served, the hospital functions of the Veterans Administration in toto, the four nonmilitary hospitals in the Canal Zone, the hospitals of the Public Health Service, and the functions, facilities, and personnel of the Public Health Service.

The Commission did not recommend transfer to the United Medical Administration of armed forces hospitals overseas, hospitals of the Bureau of Indian Affairs and of the Bureau of Prisons, or of other small hospital functions such as those of the Tennessee Valley Authority and the Atomic Energy Commission.

Further recommendations were that the present inconsistency in policy between the federal hospital construction program and federal aid to nonfederal hospitals under the Hill-Burton Act be ended, that control of medical policy in the armed services be exercised by the Secretary of Defense, that the United Medical Administration give constant attention to national defense measures, that medical and technical personnel in the United Medical Administration be selected on a career service basis, that a survey be made to determine needs for emergency aid to medical schools, and that highest priority be given to research, preventive medicine, public health, and education.

TEXAS UROLOGICAL SOCIETY

The Texas Urological Society will meet at the Shamrock Hotel, Houston, on November 28. The meeting, consisting of clinics, open discussions, luncheons, and a banquet, will be open to all physicians interested in urology.

The meeting will immediately precede the Post Graduate Medical Assembly of South Texas in the same location. Physicians desiring to attend should notify Dr. Tryon Robinson, 920 Westheimer Road, Houston 6.

TEXAS HEALTH AND MEDICAL BOARDS

Drs. L. S. Oates, Center; O. B. Kiel, Wichita Falls; and J. P. Burden, San Angelo, were appointed to the State Board of Health by the late Governor Beauford Jester on June 14. Terms for the three doctors expire in 1955.

New appointments to the Board of Medical Examiners made by the late Governor Beauford Jester on June 20 include those of Drs. H. L. Klotz, Austin; W. C. Morrow, Greenville; and Denton Kerr, Houston. R. L. Martin, D. O., Mount Pleasant, was the fourth appointee. All four terms are for six years.

Officers who were re-elected August 2 were Drs. J. T. Lawson, Bowie, president; H. L. Klotz, Austin, vice-president; and M. H. Crabb, Fort Worth, Secretary.

The first State Board of Examiners in the Basic Sciences has been appointed by Governor Allan Shivers. The six members are Asa C. Chandler, Ph. D., professor of biology at Rice Institute, Houston; Henry B. Hardt, Ph. D., chairman of the department of chemistry at Texas Christian University, Fort Worth; W. Mayne Longnecker, Ph. D., professor of biology at Southern Methodist University, Dallas; Cornelia M. Smith, Ph. D., chairman of the Department of Biology at Baylor University, Waco; Ophelia C. Wesley, acting head of the Department of Biology at Daniel Baker College of Southwestern University, Brownwood; and Brother Raphael Wilson, C.S.C., premedical adviser at St. Edward's University, Austin.

Terms of office will be six years for Drs. Hardt and Chandler, four years for Drs. Longnecker and Smith, and two years for Dr. Wesley and Brother Wilson.

A nine-member board for Texas state hospitals and special schools was announced by Governor Allan Shivers on July 23. The appointments had been made by the late Governor Beauford Jester.

Members are Dr. Edgar Ezell, Fort Worth psychiatrist; Dr. W. C. Goddard, Austin physician; W. W. Barnett, Mexia; Claud Gilmer, Rock Springs, former speaker of the House of Representatives; the Right Rev. John E. Hines, Austin, bishop coadjutor of the Episcopal diocese of Texas; R. C. Lanning, Jacksboro, former state senator; W. N. Martin, Vernon; Mrs. Lawrence Tarlton, Fort Worth, member of the executive committee of the Texas Society for Crippled Children, Inc.; and H. B. Zachry, San Antonio.

Mr. Gilmer was designated as acting chairman for organizational purposes, and the board will elect its own officers at its first meeting. Board members on September 1 took over the administration of all but three institutions which have previously been known as "eleemosynary institutions."

SOUTHWESTERN MEDICAL SCHOOL

Dr. Max N. Huffman of Southwestern Medical School of the University of Texas, Dallas, has been awarded a research grant by Sharpe and Dohme, Inc., Philadelphia. The grant is to support Dr. Huffman's program for the further development and testing of certain compounds believed to be active against the tubercle bacillus.

The National Institute of Mental Health in Washington has made grants totaling $20,000 to Southwestern Medical School to provide training personnel for graduate and undergraduate psychiatry students, reports the Fort Worth *Star-Telegram*. One-half of the grants will be used to provide teachers for each category of students, says Dean W. Lee Hart.

SAN ANTONIO TUMOR SEMINAR

The sixth annual Tumor Seminar, sponsored by the San Antonio Society of Pathologists and the Texas Society of Pathologists and featuring Dr. Rupert A. Willis of London, will be held in the auditorium of the Fourth Annex, Brooke General Hospital, San Antonio, on October 29. Eighteen cases will be presented. All pathologists are invited to attend but the 100 boxes of slides which are available will be allocated first to members of the Texas Society of Pathologists.

In the evening a dinner at La Villita will be given for attending pathologists and their wives.

Dr. Willis, the Sir William H. Collins professor of human and comparative pathology at the Royal College of Surgeons, London, is also research pathologist at the Royal Cancer Hospital, London. He was formerly pathologist at the Alfred Hospital, consultant pathologist to the Austin Hospital for Chronic Diseases, and lecturer on the pathology of tumors in the University of Melbourne, Australia.

Dr. Willis will have a full itinerary during his visit in America, including a four-weeks tour of Texas. Arriving in San Antonio the week of October 23, he and Mrs. Willis will be the guests of Brooke General Hospital for three days before the tumor seminar. He will then go to Scott and White Clinic, Temple, and the same week to a tumor conference in Galveston. His next stop will be in Fort Worth for a one-day tumor conference; then he will lecture at Southwestern Medical College, Dallas, as a guest of Fort Worth and Dallas pathologists. Next, he will be guest speaker before joint meetings of Baylor University College of Medicine and the staff of the M. D. Anderson Hospital for Cancer Research, Houston. From Houston Dr. Willis will go to Oklahoma, St. Louis, Chicago, Wisconsin, Washington, D. C., and New York.

Additional information about the seminar in San Antonio or Dr. Willis' appearances elsewhere may be obtained from Dr. B. F. Stout, 729 Medical Arts Building, San Antonio.

OKLAHOMA CITY CLINICAL CONFERENCE

Seventeen speakers of note will be leaders at the nineteenth annual fall conference of the Oklahoma City Clinical Society to be held in Oklahoma City, October 24-27. The usual features of general assemblies, postgraduate courses, a clinical-pathological conference, round-table luncheons, a smoker, dinner meetings, and commercial exhibits will be included in the registration fee of $15.

The guest speakers for the conference include Drs. Lauren V. Ackerman, pathology, Washington University School of Medicine, St. Louis; Willard M. Allen, obstetrics and gynecology, Washington University School of Medicine, St. Louis; Joseph S. D'Antoni, medicine, Tulane University, New Orleans; Ralph K. Ghormley, orthopedic surgery, University of Minnesota, Rochester; Horace L. Hodes, pediatrics, Johns Hopkins School of Medicine, Baltimore; John F. Holt, roentgenology, University of Michigan School of Medicine, Ann Arbor; Ernest E. Irons, President of the American Medical Association, Chicago; M. Digby Leigh, anesthesiology, Vancouver General Hospital, Vancouver, B. C., Canada; Francis M. Lynch, dermatology, University of Minnesota School of Medicine, Minneapolis; Carl A. Moyer, surgery, Southwestern Medical School of the University of Texas, Dallas; Louis H. Newburgh, internal medicine, University of Michigan School of Medicine, Ann Arbor; John Parks, obstetrics and gynecology, George Washington University School of Medicine, Washington; Dalton K. Rose, urology, Washington University School of Medicine, St. Louis; Arno E. Town, ophthalmology, Jefferson Medical College, Philadelphia; James Ross Veal, surgery, Georgetown University School of Medicine, Washington; Joseph B. Vander Veer, internal medicine, University of Pennsylvania School of Medicine, Philadelphia; and John M. Waugh, surgery, University of Minnesota, Rochester.

Further information may be obtained from the Executive Secretary, 512 Medical Arts Building, Oklahoma City.

INDUSTRIAL HEALTH CONFERENCE

The Gulf Coast Regional Conference on Industrial Health will be held at the Rice Hotel in Houston, October 6 and 7. Sponsoring agencies are the Texas State Health Department, the public health committee of the Houston Chamber of Commerce, Baylor University College of Medicine, Council on Industrial Health of the American Medical Association, the Gulf Coast Chapter of the American Society of Engineers, the Houston Branch of the American Association of Industrial Nurses, the Industrial Hygiene Foundation of America, Inc., the Texas Manufacturers' Association, and the Harris County Medical Society.

Speakers from out of the state will include Manfred Bowditch, director of health and safety of the Lead Industries Association, New York; Dr. Allan J. Fleming, assistant medical director of E. I. Du Pont de Nemours and Co., Wilmington, Del.; Allen D. Brandt, Sc. D., industrial hygiene engineer of Bethlehem Steel Co., Bethlehem, Pa.; Dr. Sherman S. Pinto, American Smelting and Refining Co., Denver; Miss F. Ruth Kahl, R. N., U. S. Public Health Service, Washington, D. C.; Dr. D. D. Irish, Dow Chemical Co., Midland, Mich.; Ross Garrett, Chicago; H. H. Schrenk, scientist director chief of the Environmental Investigations Branch of the U. S. Public Health Service; Dewey Dorsett, general manager of the Association of Casualty and Surety Companies, New York; Ross Garrett, industrial consultant, Houston and Chicago; and Dr. Shields Warren, representative of the Atomic Energy Commission, Washington, D. C.

Topics to be considered will be of interest to industrial physicians, nurses, public health workers, and safety engineers as well as those concerned with problems of industrial wastes.

A special invitation has been extended to members of the State Medical Association to attend the conference, the registration fee for which is $3.50. Advance registration may be made by writing the Industrial Health Conference, Houston Chamber of Commerce, P. O. Box 2371, Houston 1.

UNIVERSITY OF TEXAS MEDICAL BRANCH

Dr. Eric Ogden, formerly chairman of the Department of Physiology at the University of Texas Medical Branch, Galveston, has accepted a similar position at Ohio State University, according to the Galveston *News.*

A new laboratory building is being provided by funds from a special bond issue to accommodate the increased size of classes at the Medical Branch. The new building will house the Departments of Bacteriology and Parasitology, Pharmacology, Biochemistry and Nutrition, and Physiology. It will also provide facilities for an expanded library.

The Jewish Men's Club of Galveston has established the Meyer Bodansky Memorial Lectureship, which will be given anually at the Medical Branch by an outstanding authority upon a subject of interest to the late Dr. Bodansky.

John C. Finerty, Ph. D., formerly associate professor of anatomy at Washington University Medical School, St. Louis, has accepted appointment as associate professor of anatomy at the Medical Branch.

Dr. Walter A. Saborido, president of the Argentine Medical Association and professor of gynecology at the Uni-

versity of Buenos Aires Medical School, was a recent visitor at the Medical Branch.

Dr. T. B. Thomas, formerly of the Department of Anatomy of the Medical Branch and now in the Department of Zoology at Carleton College, Northfield, Minn., has been doing special work in the Tissue Culture laboratory of the Medical Branch.

LONE STAR STATE MEDICAL ASSOCIATION

The Lone Star State Medical Association held its sixty-third annual session in Dallas during June, reports the Waco *Tribune-Herald.* Speakers included Drs. Perry D. Beal, Houston; Curtice Rosser, professor of proctology, and Carl A. Moyer, professor of experimental surgery at Southwestern Medical College, Dallas; and Charles Drew, professor of surgery at Howard University, Washington, D. C. Selected dry clinics were conducted at Parkland Hospital during the session.

Dr. Drew in his lecture, "The Problems of Negro Health," stated that many of the problems can be traced to the economic condition of the Negro.

Officers for 1949-1950 are Drs. C. B. Friday, Seguin, president; A. L. Hunter, Marlin, president-elect; B. E. Howell, Dallas, first vice-president; C. N. Atkinson, Clarksville, second vice-president; M. L. Edwards, Hawkins, general secretary; H. L. Brownlow, Corpus Christi, assistant secretary; and H. D. Patton, Palestine, treasurer.

CONSUMERS' RESEARCH COMMENTS ON SOCIALIZED MEDICINE

An editorial in the September, 1949, issue of *Consumers' Research Bulletin* encourages consumers to become aware of the problem of socialized medicine, which the writer of the editorial points out should not be chosen by consumers merely "because they have been taken in by as shrewd an advertising and promotional campaign as was ever put on by patent medicine manufacturers in their palmiest days."

He suggests that persons who wish a careful analysis of the arguments for compulsory health insurance obtain "A Brief on Compulsory Health Insurance under Federal Legislation" by Kenneth C. Crain, reprinted from *Hospital Management,* January, 1939, and available from that journal, 100 East Ohio Street, Chicago 11.

MEETINGS OF INTEREST

Meetings of interest in the near future include the following:

National Gastroenterological Association, Boston, October 24-26, 1949. Further information may be obtained by writing the Secretary, National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

Inter-American Congress of Radiology, Santiago, Chile, November 11-17, 1949. Those desiring to attend should write Dr. James T. Case, Regional Secretary for the United States, 55 East Washington Street, Chicago 2.

TEXAS CANCER BULLETIN GRANT

The *Texas Cancer Bulletin,* edited by R. W. Cumley, Ph. D., and published by the M. D. Anderson Hospital for Cancer Research; the American Cancer Society, Texas Division; the Committee on Cancer of the State Medical Association of Texas; and the Texas State Department of Health, has received a grant of $19,600 from the National Cancer Institute so that it may be made available to physicians throughout the nation, reports the *Texas Cancer Triangle.* The publication will henceforth be known as the *Cancer Bulletin.*

OBSTETRICS TO BE TAUGHT BY TELEVISION

Members of the medical profession are invited to attend a graduate teaching program in obstetric and gynecologic procedures presented by television at the Lewis Memorial Maternity Hospital, Chicago, during the week of October 24-29. The program will be directed by Dr. Herbert E. Schmitz, professor of obstetrics and gynecology at the Stritch School of Medicine of Loyola University. The television presentation will be made possible through the cooperation of Ciba Pharmaceutical Products, Inc., and the Radio Corporation of America.

A number of visiting professors of note will assist in the lectures and demonstrations covering a wide variety of obstetric and gynecologic subjects.

Medical Books for Philippines

From eight hospital libraries in the Philippines have come requests for more than 700 medical books and more than 100 medical journals. Mr. H. A. Dunn, custodian of the Main Building of the University of Texas, wants to obtain used medical books and periodicals for these libraries. In the past three years he has sent more than 50,000 books to the libraries of China and the Philippines, including about 375 medical books. Persons who have contributions may get in touch with Mr. Dunn, whose address is Room 18, Main Building, The University of Texas, Austin.

HOUSTON'S CITY-COUNTY HOSPITAL

Beginning with the contribution of $1,500,000 by H. R. Cullen, Houston philanthropist, funds for the proposed city-county hospital to be erected in the Texas Medical Center, Houston, are rapidly being pledged, reports the Houston *Post.* The city will contribute $1,750,000 of bonds already voted; the county will raise $1,500,000 through a bond issue; and a site in the Medical Center has been assured. The new 600 bed charity hospital will replace Jefferson Davis Hospital, which will be converted to a tuberculosis hospital, for which the state has pledged $500,000.

COURSES IN DISEASES OF CHEST

Four postgraduate courses in diseases of the chest will be offered during the autumn months under the sponsorship of the American College of Chest Physicians. They are as follows: Chicago, September 19-23, tuition $50; Minneapolis, October 20-22, tuition $20; New York, November 14-18, tuition $50; and San Francisco, December 5-9, tuition $50. The courses in Minneapolis and San Francisco will be presented in cooperation with the University of Minnesota and with the University of California Medical School and Stanford University School of Medicine.

Additional information may be obtained from the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10.

INTERNATIONAL PUBLICATIONS EXCHANGE LIST

The United Nations Educational, Scientific, and Cultural Organization plans to publish a manual on the international exchange of publications which will list the institutions throughout the world which are willing to exchange their own publications or duplicate material which they may have.

Libraries, universities, scientific institutions, learned societies, and other institutions are invited to list their full name and address, the titles of publications available for exchange, and the conditions under which such exchange can be arranged, sending this information to the Unesco Clearing House for Publications, 19 Avenue Kléber, Paris, 16e prior to October 1.

TEXAS PEDIATRIC SOCIETY

OCTOBER 7

Call to Order—Dr. John K. Glen, Houston.

Dr. Byron York, Houston, Presiding

Causes of Mortality among Premature Infants Delivered in Last Ten Years at Chicago Lying In Hospital—Dr. Edith Potter, Chicago.
Office Management of Acute Upper Respiratory Infections—Dr. Wallace Sako, New Orleans.
Recent Advances in Common Communicable Diseases—Dr. Charles A. Janeway, Boston.
Luncheon.

Dr. Robert L. Moore, Dallas, Presiding

Pediatric Emergencies—Dr. Wallace Sako, New Orleans.
Clinical Characteristics of Virus Diseases—Dr. Charles A. Janeway, Boston.
Rh Diagnosis—Dr. Edith Potter, Chicago.
Business Meeting—Dr. John K. Glen, Houston, Presiding.

OCTOBER 8

Dr. L. O. Godley, Fort Worth, Presiding

Treatment of Erythroblastosis—Dr. Edith Potter, Chicago.
Diagnosis and Management of Congenital Heart Diseases Amenable to Surgery—Dr. Wallace Sako, New Orleans.
New Responsibilities in Pediatrics—Dr. Charles A. Janeway, Boston.

The fall clinical meeting of the Texas Pediatric Society under the auspices of District 3 will be held October 7-8 at the Gunter Hotel in San Antonio. The program outlined above will be given with opportunity for questions following each address.

Entertainment the evening of October 7 will include a boat trip, dinner, and music with Dr. Charles B. Alexander, San Antonio, as master of ceremonies.

PERSONALS

Dr. H. Frank Carman, Dallas, will speak at the Southern Tuberculosis Conference in Memphis, Tenn., September 15-17.

Dr. Tate Miller, Dallas, was the principal speaker at the organizational meeting of the Southern Colorado Medical Society on June 18 in Pueblo, reports *The Journal of the American Medical Association.*

Dr. Lee Cady, acting manager of the Veterans Administration Hospital at Houston, has been appointed permanent manager of the hospital. He has been acting manager since January 31. Recently Dr. Cady was also appointed assistant professor of clinical medicine in Baylor University College of Medicine.

Dr. Carl Jordan, director of Tarrant County Health Department, Fort Worth, will discuss "The Epidemiology of Human Brucellosis" during the Symposium on Brucellosis in Bethesda, Md., September 22-23. The symposium is sponsored by the National Institutes of Health, the Bureau of Animal Industry, and the National Research Council.

Dr. Charles Cornwell, Marlin, won highest honors, a trophy, in the annual Marlin Country Club golf tournament, reports the Marlin *Democrat.*

Dr. J. H. Hejtmancik married Miss Margie Beth Spiller, daughter of *Dr. W. F. Spiller* of Galveston, in Galveston recently.

LIBRARY SECTION

PACKAGE SERVICE

The package library consists of collections of reprints and other periodical material on various subjects, prepared for lending to members of the Association. Requests for packages should be addressed "Library, State Medical Association of Texas, 700 Guadalupe Street, Austin, Texas." Twenty-five cents in stamps should be enclosed with the request to cover postage and part of the expense of collecting the material. Packages are allowed to remain in the hands of the borrower for 14 days.

ACCESSIONS

The following additions were made to the Library during August:

Reprints received, 1,224.

Journals received, 339.

Books received, 18.

Photoradiography in Search of Tuberculosis, by Zacks; *Psychological Medicine,* by Curran and Guttmann; *Treatment in Proctology,* by Turell; and *An Account of the Schools of Surgery, Royal College of Surgeons, Dublin,* by Widdess, from Williams & Wilkins Company, Baltimore.

Shearer's Manual of Human Dissection, by Tobin (editor), and *Blakiston's New Gould Medical Dictionary* (2 copies), by Jones and others (editors), from Blakiston Company, Philadelphia.

A Textbook of Neuropathology, by Lichtenstein; *Modern Clinical Syphilology,* by Stokes and others; and *The American Illustrated Medical Dictionary,* by Dorland, from W. B. Saunders Company, Philadelphia.

Index to Surgery, Gynecology and Obstetrics, 1925-1945, by Davis (editor), from the Franklin H. Martin Memorial Foundation, Chicago.

America's Health: A Report to the Nation, by the National Health Assembly, from Harper and Brothers, New York.

Modern Practice in Psychological Medicine, by Rees (editor), from Paul B. Hoeber, Inc., New York.

The Epitome of Andreas Vesalius, by Lind (translator), from the Macmillan Company, New York.

Mental Hygiene in Public Health, by Lemkau, from McGraw-Hill Book Company, Inc., New York.

International World Who's Who, by Samson (editor), from Samson Publishing Company, Inc., New York.

A Century of Medicine in San Antonio, by Nixon, and *The Medical Story of Early Texas,* by Nixon, from the author, Pat Ireland Nixon, M. D., San Antonio.

SUMMARY OF SERVICE

Local users, 61. Borrowers by mail, 97.
Items consulted, 873. Packages mailed, 99.
Items borrowed, 495. Items mailed, 487.
Films loaned, 29.
Total number of items consulted and loaned, 1,855.

LIBRARY NEEDS

The journals listed are needed by the Library of the State Medical Association to complete volumes for binding. Any of these numbers will be acceptable either as a gift or for purchase. It is preferable that the Library, 700 Guadalupe, Austin, be notified regarding items available, and the prices of such items, if any, before shipment is made.

Journals needed by the Library of the State Medical Association are as follows:

British Journal of Surgery, Vol. 27, No. 1 (Jan.), No. 2 (April) 1939.

Bulletin of John Sealy Hospital, Vol. 1, No. 1 (Feb.), No. 6 (Oct.) 1939.

Calcutta Medical Journal, Vol. 36, No. 3-6 (March-June) 1939.

Industrial Medicine, Vol. 8, No. 2 (Feb.) 1939.

Journal of Allergy, Vol. 10, No. 1 (Nov.) 1938.

Journal of International College of Surgeons, Vol. 2, No. 1-4 (Feb., April, June, Aug.) 1939.

Journal of Medical Association of Georgia, Vol. 28, No. 9 (Sept.) 1939.

Journal of Missouri State Medical Association, Vol. 36, No. 5 (May) 1939.

Medical Annals of District of Columbia, Vol. 8, No. 12 (Dec.) 1939.

Medical Record, Vol. 149, No. 4 (April) 1939.

Mississippi Doctor, Vol. 16, No. 1-8 (June-Jan.) 1938-1939.

Ohio State Medical Journal, Vol. 35, No. 1 (Jan.) 1939.

Pennsylvania Medical Journal, Vol. 42, No. 8 (Aug.) 1939.

Proceedings of Staff Meetings of Mayo Clinic, Vol. 21, No. 11 (May 29) 1946.

Southern Medicine and Surgery, Vol. 101, No. 1-5 (Jan.-May) 1939.

Southwestern Medicine, Vol. 24, No. 1 (Jan.) 1940.

Surgery, Vol. 5, No. 4 (April) 1939.

MOTION PICTURE FILM LIBRARY

Motion picture films on medical subjects, 16 mm., both silent and sound, some in color, and suitable for either medical or lay audiences, are available for loan to county medical societies, hospital staffs, or individual physicians, on request. Borrowers will be required to pay only the cost of shipment of the films, by express, with insurance, and for any damage to films in the hands of the borrower.

Requests for films should be addressed to "Motion Picture Film Library, State Medical Association of Texas, 700 Guadalupe Street, Austin, Texas." A list of available films, with descriptions, will be furnished on request.

The following motion picture films were loaned by the Film Library during August:

The Anemias (Lederle Laboratories)—Dr. Edward H. Martin, Overton.

Anesthesia, Regional (Winthrop Chemical Co.)—Gonzales County Medical Society, Nixon.

Antitoxins, Globulin Modified (Lederle Laboratories)—Dr. G. Levin, Houston.

As Others See Us (American Hospital Association)—Methodist Church, Ozona.

Blood Transfusion (British Information Services)—Comal Sanitarium, New Braunfels.

Blood Transfusion, Technique of (Mead Johnson)—Comal Sanitarium, New Braunfels.

Breech Extraction with Forceps (Mead Johnson)—Drs. Duff and Pittard, Anson.

Cervical Smear (Dr. Karl Karnaky)—Drs. Duff and Pittard, Anson.

Choose to Live (U. S. Public Health Service)—Dublin Rotary Club, Dublin.

Diphtheria and Croup (Lederle Laboratories)—Hermann Hospital School of Nursing, Houston.

The Doctor Speaks His Mind (American Cancer Society)—Methodist Church, Ozona.

Dysmenorrhea, Primary (G. D. Searle & Co.)—Dr. Edward H. Martin, Overton.

Folvite in the Treatment of Anemias (Lederle Laboratories)—Dr. Edward H. Martin, Overton.

Gastrectomy, Safer (Billy Burke Productions)—University of Houston School of Nursing, Houston.

Golden Glory (Standard Brands, Inc.)—Conroe and Houston Hub Club Convention, Conroe.

Hematology, Animated (Armour & Co.)—Dr. Edward H. Martin, Overton.

Lease on Life (U. S. Public Health Service)—Methodist Church, Ozona.

Lesions of the Vulva, Vagina, and Cervix (Dr. Karl Karnaky)—Dr. Edward H. Martin, Overton, and Wilson and Jones Hospital Staff, Sherman.

Malaria (British Information Services)—Dr. Edward H. Martin, Overton.

Poliomyelitis, Sister Kenny Method of Treatment of (Dr. Herbert Hipps)—Gonzales County Medical Society, Nixon.

Problem Child (Pet Milk Company)—Nurses Assistant School, Hermann Hospital, Houston.

Scarlet Fever (Lederle Laboratories, Inc.)—Hermann Hospital School of Nursing, Houston.

Surgical Treatment for Splenic Flexure Carcinoma with Solitary Liver Metastasis (Dr. Philip Thorek, Chicago)—Wilson and Jones Hospital Staff, Sherman.

Time Is Life (American Cancer Society)—Methodist Church, Ozona.

Traitor Within (American Cancer Society)—Rotary Club, Tahoka.

Trichomonal and Monilial Vaginitis (G. D. Searle & Co.)—Wilson and Jones Hospital Staff, Sherman.

Varicose Veins and Their Complications (Becton, Dickinson & Co.)—University of Houston School of Nursing, Houston.

Varicose Veins, Treatment of (G. D. Searle & Co.)—Dr. G. Levin, Houston, and Wilson and Jones Hospital Staff, Sherman.

When Bobby Goes to School (Mead Johnson)—Conroe and Houston Hub Club Convention, Conroe, and Dublin Rotary Club, Dublin.

BOOK NOTICES

[1]A-B-C's of Sulfonamide and Antibiotic Therapy

Perrin H. Long, M. D., F.R.C.P., Professor of Preventive Medicine, Johns Hopkins University School of Medicine; Physician, Johns Hopkins Hospital. Cloth, 231 pages. Price $3.50. Philadelphia and London, W. B. Saunders Company, 1948.

The title of this book well describes its contents. It is a small, concise manual covering types of preparations, indications, contraindications, dosages, and toxic reactions to the sulfonamides and antibiotics.

The first fifty-six pages include a general discussion of the sulfonamides, penicillin, and streptomycin which is well presented and informative. The remainder of the book is made up of brief, concise discussions of the application of these preparations in each specific disease or condition in which they have been used. It is a simple, ready reference book in which can be found at a glance the preparation of choice and its dosage for any specific disease entity.

[2]Mayo Clinic Diet Manual

The Committee on Dietetics of the Mayo Clinic. Paper, 329 pages. Price, $4. Philadelphia and London, W. B. Saunders Company, 1949.

The "Mayo Clinic Diet Manual" is an excellent reference book. It includes regimens for almost any condition in which diet is a useful adjunct to therapy.

[1]*R. M. Bain, M. D., Austin.*
[2]*David W. Quick, Jr., M. D., Beaumont.*

The diets are well organized and are presented in a clear and concise manner, and the explanatory notes are complete. The volume is well indexed.

Many physicians who ordinarily give vague instructions concerning diets because of lack of a ready reference will find the specificity of this volume a great aid in the prescription of diets.

[3]The Case Against Socialized Medicine

Lawrence Sullivan. Cloth, 54 pages. Price, $1.50. Washington, D. C., Statesman Press, 1949.

The journalist Lawrence Sullivan brings doctors something to think about. Socialization or regimentation of medicine has far-reaching effects.

This short book should be placed in the hands of all those organized to support this drastic change. It is designed to inform readers of the danger—not to medicine alone—and to plead that Americans pay heed before it is too late. The theme is "How can we afford to give up our strong position in the world for one that is so weak?"

This man has been on the scene; he knows. Plenty of figures are given. It is the very history of compulsory insurance.

One short chapter is devoted to an explanation of the way statistics are juggled to show that American medicine is doing only one-half the job. The last few pages are directed to bureaucratic government. The book is easily read in two hours.

[4]An Elementary Atlas of Cardiography

H. Wallace-Jones, M. D., M. Sc., F.R.C.P., Honorary Consulting Physician, Royal Liverpool United Hospital; E. Noble Chamberlain, M. D., M. Sc., F.R.C.P., Honorary Physician, Royal Liverpool United Hospital; and E. L. Rubin, M. D., F.F.R., D.M.R.E., Honorary Radiologist, Royal Liverpool United Hospital. Cloth, 108 pages. Price, $3. Bristol, John Wright & Sons Ltd., 1948.

This volume, though brief, is written with exceptional clarity. It is designed for beginners and provides a basic knowledge of the common cardiac abnormalities. Its division into two sections separating entirely electrocardiography and radiography emphasizes to the beginner that electrocardiograms and x-ray films constitute only a part of the complete clinical study. The illustrations in the radiographic section are exceptionally well chosen. It is recommended as a teaching aid.

[5]Handbook for the Medical Secretary

Miriam Bredow, Dean of Women, Eastern School for Physicians' Aides. Second edition. Cloth, 389 pages. Price, $2.75. New York, Toronto, London, McGraw-Hill Book Company, Inc., 1948.

There is a shortage of well trained medical secretaries. Any one who has made a search for publications which may be of aid in training an inexperienced secretary in the somewhat exacting duties of a medical office will find that this field of publication has been generally neglected.

This book is a second edition prepared by Miss Bredow, who has had extended experience in medical secretarial work and in teaching the profession. It is almost four hundred pages long but contains no surplus material. The prospective medical secretary should read it slowly and carefully because each page contains a wealth of material, and then it should be read again. Even the experienced secretary who thinks herself entirely proficient will find many worth-while methods of bettering her service.

This book is to be recommended as standard equipment in all doctors' offices for aid in training new office help, for annual perusal of regular secretarial staff, and for ready reference when needed.

[6]British Surgical Practice, Vol. 5

Sir Ernest Rock Carling, F.R.C.S., F.R.C.P., Consulting Surgeon, Westminster Hospital, and J. Paterson Ross, M. S., F.R.C.S., Surgeon and Director of Surgical Clinical Unit, St. Bartholomew's Hospital; Professor of Surgery, University of London. Cloth, 532 pages. Price, $15. St. Louis, C. V. Mosby Company, 1948.

The fifth volume of this ambitious work contains much information of value for the general practitioner and the general surgeon. The principal use for the book would seem to be for orientation, since the information in most instances is not sufficiently detailed to permit the physician to carry out treatment. However, there is a good bibliography at the end of each article.

The orthopedic sections are well written. Outstanding is the article by McMurry on "Internal Derangements of the Knee." The section on joint tuberculosis, by N. W. Nesbitt, is pithy.

The format of the book in semi-outline form, with excellent indexing and marginal summaries, makes it easy to locate information. The printing, binding, and illustrations are good.

[7]Midwifery

Clifford White, M. D., B. S. (Lond.), F.R.C.P. (Lond.), F.R.C.S. (Eng.), F.R.C.O.G.; Frank Cook, B. Sc. (Lond.), M. B., B. S., F.R.C.S. (Eng.), F.R.C.O.G., and William Gilliatt, C.V.O., M. D., M. S., F.R.C.P. (Lond.), F.R.C.S. (Eng.), F.R.C.O.G. Eighth edition. Cloth, 560 pages. Price, $6. Baltimore, Williams & Wilkins Company, 1948.

This book presents a comprehensive review of all phases of obstetrics including two chapters on the newborn infant. There are numerous illustrations to aid the reader. The subjects are dealt with in a clear, concise manner, though for the most part rather briefly.

All material presented in this book is practical and may be recommended to both students and practitioners. Treatments as outlined coincide for the most part with those given by American authors.

[8]Blood Transfusion

Elmer L. DeGowin, M. D., Associate Professor of Internal Medicine, State University of Iowa; Director, Blood Transfusion Service, University Hospital; Robert C. Hardin, M. D., Assistant Professor of Internal Medicine, State University of Iowa; and John B. Alsever, M. D., Senior Surgeon, U. S. Public Health Service. Cloth, 587 pages. Price, $9. Philadelphia and London, W. B. Saunders Company, 1949.

This book is well written and well indexed so that it can be of great value as a reliable reference book when any question arises relative to the administration of blood or relative to any complication arising from the administration of blood or plasma.

The authors go into great detail to clarify each subject. Their presentation of the blood groups and subgroups and the blood types and subtypes is detailed and should help to clear some of the confused ideas currently held on these subjects.

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[3]*L. L. D. Tuttle, M. D., Houston.*
[4]*Herbert J. Bell, M. D., El Paso.*
[5]*John F. Thomas, M. D., Austin.*
[6]*M. H. Leonard, M. D., El Paso.*
[7]*Otto Brandt, M. D., Austin.*
[8]*Jay J. Johns, M. D., Taylor.*

Their description of technical details in withdrawing and administering blood, together with the chapter on transfusion complications in the recipient, deserves careful study by every physician who gives or even orders transfusions.

Since the use of blood transfusion is so common today and since there is such diversity of opinion concerning the use of blood and its derivatives, this book is earnestly recommended as a reference book to be added to each clinician's library.

[9]**Neoplasms of Bone and Related Conditions**

Bradley L. Coley, M. D., Attending Surgeon, Bone Tumor Department, Memorial Hospital for Cancer and Allied Disease; Assistant Professor of Clinical Surgery, Cornell. Cloth, 765 pages. Price, $17.50. New York, Paul B. Hoeber, Inc., 1949.

This book covers the entire subject of bone tumors and allied diseases. The author presents many personal observations and stresses clinical diagnosis. A detailed discussion of histopathology is wanting for many of the tumor types. The author assumes that the College of Surgeons classification of bone tumor is the final word and he uses it exclusively.

The chapter on blood changes relating to diseases of bone is all inclusive and each disease is discussed separately. This chapter, written by Dr. Woodard, should prove of inestimable help in the clinical analysis of bone diseases.

Dr. Coley devotes considerable space to the controversial question of aspiration biopsy. He is convincing and proves his argument that aspiration biopsy has a definite place in the diagnosis of neoplasm of bone.

The chapter on treatment deserves careful reading.

This book makes easy reading and there are many fine detailed radiograms depicting the various bone lesions. The reviewer recommends Dr. Coley's book as a quick diagnostic reference. As the author states, reference to histopathologic considerations should be made in other texts written specially for this purpose.

An extensive bibliography is included.

[10]**The Pharmacologic Principles of Medical Practice**

John C. Krantz, Jr., Professor of Pharmacology, School of Medicine, University of Maryland, and C. Jelliff Carr, Associate Professor of Pharmacology, School of Medicine, University of Maryland. Cloth, 980 pages. Price $10. Baltimore, Williams & Wilkins Co., 1949.

This is a well written, clear, concise, practical book for the medical student and the practicing physician who daily uses drugs in the treatment of his patients. "Principles" explain what to do and why, and "practice" how to do it and when.

The subject matter is arranged according to the physiologic systems of the body. The book includes a synopsis of the physiologic and biochemical functioning of these systems as a basis for understanding and interpretation of the drug action.

Drugs in every day use have been selected for discussion, with no attempt being made to include all drugs used in treatment. The authors state in the preface that the phases of clinical medicine included in the book were reviewed and criticized by specialists in various fields.

I strongly recommend this excellent volume to everyone using drugs in the treatment of patients.

[11]**Obstetric Analgesia and Anesthesia**

Franklin F. Snyder, M. D., Associate Professor of Obstetrics and Associate Professor of Anatomy, Harvard Medical School. Cloth, 401 pages. Price, $6.50. Philadelphia and London, W. B. Saunders Company, 1949.

This book will be welcomed primarily by the doctors doing some obstetrics, pediatrics, or obstetric anesthesiology, but anyone interested in a new scientific approach to the better understanding of fetal physiology will enjoy it.

What occurs to the intra-uterine fetus under the influence of the various analgesia and anesthesia drugs has never before been reported with facts from direct observation. Dr. Snyder has devised means for observing the intra-uterine physical and respiratory activities and responses of premature, mature, and postmature fetuses under controlled conditions.

The first half of this well-written and easily-read book is devoted to the pharmacology factor in labor, respiration, and incidence and types of respiratory injury before birth. If intra-uterine respiration occurs before birth, and Dr. Snyder has rather conclusive proof that it does, the causative factors of intra-uterine pneumonia, atelectasis, and asphyxia of the newborn can be prevented frequently, and these troubles, when better understood, can be more intelligently treated.

The second half of this book is a report on Dr. Snyder's observations of the intra-uterine, extra-uterine, and newborn babies in regard to their changes of activity, chiefly respiratory, to the various anesthetic and analgesic drugs in common use. Dr. Snyder does not take sides nor does he advocate any particular analgesic or anesthetic agent or method. He tries to correlate the fetal respiratory response and the suppression of the fetal activities to the depth and success of analgesia and anesthesia produced in the mother. From his observations the author reports most favorably on the narcotic gases, nitrous oxide, ethylene, and cyclopropane, as having the widest margin of safety to the fetus and to the mother.

[12]**Neuroradiology**

Alexander Orley, M. D., F.F.R., D.M.R., and E., Hon. Consulting Radiologist, West End Hospital for Nervous Diseases, London. Cloth, 421 pages. Price, $11.50. Springfield, Ill., Charles C. Thomas, 1949.

"Neuroradiology" by Alexander Orley is compiled largely from his experience during the war at the Hurstwood Park E.M.S. Neurosurgical Hospital, London. Considerable emphasis is given to trauma and much space is devoted to radiographic technique, including the injection of the cranial arteries and peripheral vessels. The technique for injection of air for encephalography is also given. A large number of topics are discussed more or less independently, with some repetition. Disease entities are developed largely by case presentation. The volume contains a generous number of illustrations. The reproduction of roentgenograms is poor; most of them are greatly reduced in size, showing little detail and often failing to reveal what is described in the legend. Diagrams accompanying reproductions of ventriculograms are of material aid, and the bibliography is well organized.

The book is well worth reading for the case material it contains, but the reproduction of the roentgenograms is disappointing.

[9]*Ben DuBilier, M. D., Austin.*
[10]*Hugh A. Kennedy, M. D., Corpus Christi.*
[11]*Charles H. Todd, Jr., Beaumont.*
[12]*Herman C. Sebested, M. D., Fort Worth.*

[13]Clinical Auscultation of the Heart

Samuel A. Levine, M. D., Clinical Professor of Medicine, Harvard Medical School, and W. Proctor Harvey, M. D., Research Fellow in Medicine, Harvard Medical School. Cloth, 327 pages. Price, $6.50. Philadelphia and London, W. B. Saunders Company, 1949.

This book is divided into four general parts: heart sounds, cardiac irregularities, cardiac murmurs, and miscellaneous auscultatory findings. The illustrations were obtained primarily from Peter Bent Brigham Hospital patients.

In this treatise the authors present an excellent discussion of the heart abnormalities as related to heart sounds. This is done by giving a complete description of each abnormal variation and illustrating it by electrocardiographic and phonocardiographic tracings. This makes a complete picture, adds to the interest of the subject, and broadens the reader's understanding.

The section on cardiac irregularities is particularly appealing because of the manner in which the various rhythm disturbances are disentangled and brought into sharp focus as clear, concise, separate entities.

This is an important book and should be studied and kept at hand by every physician.

[14]Viral and Rickettsial Infections of Man

Thomas M. Rivers, M. D., Director of the Hospital, The Rockefeller Institute for Medical Research. Cloth, 587 pages. Price, $5. Philadelphia, London and Montreal, J. B. Lippincott Company, 1948.

This volume fills the need for a book on viral and rickettsial infections of man to which virologists, medical students, and practicing physicians may turn for information. Since viruses and rickettsiae are obligate parasites and multiply only in association with living cells, much of the book deals with clinical and pathologic states induced in natural or experimental hosts. For those interested in public health aspects, sections on epidemiology and control measures are included.

This book attests to the growing importance of virology in the study of infectious diseases. While the practicing physician may be disappointed by the relative lack of information on specific therapy, nevertheless the book is strongly recommended to those who would keep abreast of developments in viral and rickettsial infections of man.

The price should not be a factor limiting the number of readers of this book as the National Foundation for Infantile Paralysis has provided substantial financial aid for preparation and publication.

[15]Abdominal Operations

Rodney Maingot, F.R.C.S., Surgeon to the Royal Free Hospital, London, and to the Southend General Hospital. Second edition. Cloth, 1,274 pages. New York, Appleton-Century-Crofts, Inc., 1948.

The 1940 two-volume edition is revised and reprinted in a single volume of 1,231 pages of text as against the 1,361 pages in the former issue. This has been accomplished not only without the sacrifice of pertinent material but with the addition of much new matter based upon the results of modern research and experience. All of the fine illustrations of the first issue have been retained and augmented by many additional ones for the clarification of the text.

The new one-volume feature of this excellent work makes it a "desk" book instead of a library shelf book—truly a surgeon's *vade mecum* to be kept at his elbow for ready reference.

[16]Coronary Artery Disease

Ernst P. Boas, M. D., Associate Physician, Mount Sinai Hospital, New York City; and Norman F. Boas, M. D. Cloth, 399 pages. Price, $6. Chicago, The Year Book Publishers, Inc., 1949.

This monograph is remarkable in that it is the first publication to be confined solely to disease of the coronary circulation. It is designed particularly for the general practitioner, but the sections on anatomy and physiology are so well done that one whose chief interest is cardiovascular disease will find them enjoyable and profitable reading. The section on differential diagnosis is likewise excellent. The discussion of treatment is naturally colored by the authors' own particular preferences. For example, the use of intravenous aminophylline is recommended, a practice that is looked upon askance in many sectors. Similarly the use of papaverine as a vasodilator is decried, whereas many cardiologists use it enthusiastically. The section on electrocardiographic diagnosis makes only the briefest mention of V leads. Deviation from the normal in leads AVL, AVR, and AVF are not described at all, which would seem a rather unusual omission in this day and age when many authorities predict that the conventional standard leads may soon be replaced entirely by the V leads.

All in all, however, the book is well done and represents a tremendous amount of effort on the part of the authors in reviewing the mountain of literature on the subject that has accumulated since the paper of Herrick in 1912. When one considers also the impressive amount of clinical experience which Dr. Boas has had, it will become apparent that he has made a significant addition to the cardiovascular literature.

[17]The Uses of Penicillin and Streptomycin

Chester Scott Keefer, M. D., Wade Professor of Medicine, Boston University School of Medicine. Cloth, 72 pages. Price, $2. Lawrence, Kan., University of Kansas Press, 1949.

The author is well qualified to write this book by virtue of heading the committee of the National Research Council which developed penicillin as a therapeutic agent. He presents a clear, concise, authoritative summary of the established facts known about penicillin and streptomycin, their forms, dosages, routes of administration, bacterial sensitivity, adverse reactions, and the effects of each on various diseases.

This book is short and not cluttered with innumerable references. It is divided into three sections, the first dealing with penicillin, the second with streptomycin, and the third with a brief but interesting story of the antibacterial agents from the time of Koch and Pasteur to Fleming and Waksman. For a handy reference in the uses of penicillin and streptomycin it is highly recommended.

[18]How to Stop Worrying and Start Living

Dale Carnegie. Cloth, 306 pages. Price, $2.95. New York, Simon and Schuster, 1948.

This book can be of material help to a physician and his patients. While the book was in possession of the reviewer

[13]*A. O. McCary, M. D., Freeport.*
[14]*J. V. Irons, Sc. D., Austin.*
[15]*M. B. Stokes, M. D., Houston.*
[16]*H. B. O'Neil, M. D., Plainview.*
[17]*Hervey W. Dietrich, M. D., El Paso.*
[18]*W. W. Harris, M. D., Austin.*

it was loaned to three patients: (1) a person with hypertension, (2) a business man who had sudden large financial loss, and (3) a 39 year old man whose wife had died six months previously. The psychosomatic nature of the complaints of these patients was manifest. Each insisted that he received much help from the book. The advice, rules, and illustrations may seem useless and simple to the well adjusted person, but for the patient who has a worry problem, use of the book can be valuable. Many of the people cited by the author have had illness along with worries, and he quotes freely from doctors.

The first thirty chapters deal with such topics and advice as "Live in Day-Tight Compartments," a teaching for which Sir William Osler is remembered; "How to Crowd Worry Out of Your Mind," and "Four Good Working Habits That Will Help Prevent Worry and Fatigue."

The last sixty pages are titled "How I Conquered Worry," and contains about twenty-five short essays on this subject by such persons as William Lyons Phelps, J. C. Penny, Ferenc Molnar, and Roger Babson.

[19]Venous Thrombosis and Pulmonary Embolism

Harold Neuhof, M. D., Clinical Professor of Surgery in Columbia University; Consulting Surgeon to Mount Sinai, Montefiore, Beth El, and Hackensack, N. J., Hospitals. Cloth, 159 pages. Price, $4.50. New York. Grune & Stratton, 1948.

This is a monograph setting forth the experiences which have resulted from the assignment by the medical board at Mount Sinai Hospital of Dr. Neuhof to study the role of pulmonary embolism as a cause of death and to work out a plan for its surgical management. It is clearly written and reports many cases and operations performed for nonfatal embolism, as well as a study of 88 fatal cases. The opinions, philosophy, and experiences of the author are set forth in detail.

The author makes a good case for the employment of operative procedures for the control of venous thrombosis, but admits that anticoagulant therapy would be more desirable if its safety could be proved. He adds a technique for the removal of intracardiac and intrapulmonary emboli by way of the right ventricle.

[19]*Dale J. Austin, M. D., Dallas.*

ORGANIZATION SECTION

STATE MEDICAL ASSOCIATION

HEALTH TALKS AVAILABLE TO LAY PRESS

Something new has been added to the public relations family of the State Medical Association and this infant literary endeavor seems to be spreading good will among the press and the public.

The afternoon papers of the state have taken kindly to the series of health talks that are distributed in the name of the Association. The series, which is offered for release four afternoons a week, deals with seasonal topics of general interest, written for the layman in terms everyone can understand. They are informative and entertaining, and at times humorous, following a course of explanation of afflictions, and at what point medical assistance is required.

Designed as educational material on health topics, the stories are made more palatable with a breezy style of writing to catch the public eye and hold interest throughout. However, they are authoritative medical information. The material is gathered from the resources of the Library of the State Medical Association and after the story is written it is again checked for medical facts by a qualified physician.

COUNTY SOCIETIES

Austin-Waller Counties Society

August 9, 1949

(Reported by R. A. Neely, Secretary)

Presentation of Case of Histoplasmosis—Robert Hettig, Houston.
Radiologic Diagnosis—Walter J. Stork, Houston.

The Austin-Waller Counties Medical Society met in Sealy on August 9 for its regular bi-monthly meeting. After the business meeting, the guest speakers gave the program outlined above. The society went on record as opposing socialized medicine in any form.

Bell County Society

June 1, 1949

(Reported by P. M. Raney, Secretary)

Coccidioidal Meningitis: Presentation of Two Cases, with Acti-Dionine Therapy—J. C. Postlewaite, Temple.

Bell County Medical Society met in regular session June 1 in Temple. Forty-five members and guests were present. J. C. Postlewaite talked on the above topic.

August 3, 1949

The educational campaign of the American Medical Association was explained by George A. Schenewerk, Dallas, chairman of the Committee on Public Relations of the State Medical Association, at the meeting of Bell County Medical Society at the Temple Country Club on August 3.

Cass-Marion Counties Society

July 13, 1949

After a dinner at which members of the Woman's Auxiliary were present, Cass-Marion Counties Medical Society met July 13 in Hughes Springs. P. M. Bailes, Taylor, guest speaker, gave a paper on cancer. Eight members were present.

Eastland-Callahan Counties Society

June 21, 1949

(Reported by W. P. Watkins, Secretary)

Surgical Aspects of Pulmonary Suppurative Disease—Clive Johnson, Fort Worth.
Medical Aspects of Pulmonary Suppurative Disease—John Wiggins, Fort Worth.

Eastland-Callahan Counties Medical Society met in Eastland on June 21 with members of the Woman's Auxiliary present as guests. It was voted to accept the constitution and by-laws as recommended. The program outlined was presented.

Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Society

July 21, 1949

(Reported by Nell W. Sanders, Secretary)

Newer Orthopedic Techniques (slides)—Louis W. Breck, El Paso.

Twenty members of Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Medical Society met in Odessa on July 21. After dinner Dr. Breck spoke on the subject indicated above, illustrating his talk with lantern slides. After his talk a question and answer period was held.

L. W. Ramey, Odessa, formerly of Van Nuys, Calif.; H. J. Roberts, Big Spring; and Dorothy Wyvell, Midland, formerly of Dallas, were elected to membership.

C. S. Britt, delegate of the society to the House of Delegates of the State Medical Association, reported on the special meeting July 13.

August 18, 1949

(Reported by Nell W. Sanders, Secretary)

Protein Deficiency in Surgical Patients—R. B. G. Cowper, Big Spring.
Discussion—Hattie Love Rankin and Frank M. James, Odessa.

Twenty members of Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Medical Society met August 18 in Midland.

Two members were accepted into the society by transfer: Rex. E. Greer, formery of Carter County, Okla., now of Midland, and Provost Hubbard, formerly of Hamilton County, now of Odessa. Alvis Johnson and J. S. Roden, both of Midland, were elected to membership upon application.

The society decided to participate in the diabetes detection drive to be held October 10-16 under sponsorship of the American Diabetes Association, and the president appointed three committee members to plan for such participation.

R. B. G. Cowper spoke on the above subject.

Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson Counties Society

July 19, 1949

(Reported by H. L. Wilder, Secretary)

Surgery in Peptic Ulcer (slides)—E. P. Reed, Amarillo.
Discussion—M. C. Overton, Jr., J. F. Elder, C. S. Hatchett, H. E. Nicholson, and K. W. Pieratt.

Fourteen members and four guests of Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson Counties Medical Society held a dinner meeting July 19 in Wheeler as guests of H. E. Nicholson and H. E. Nicholson, Jr. In the absence of the president and vice-presidents, H. L. Wilder, secretary, opened the meeting and asked Dr. Nicholson to preside.

Mr. Grainger McIlhany, state representative, was accorded the appreciation of the society for his aid in obtaining passage of the Minimum Standards bill. Dr. Reed lectured on the topic given above, illustrating his talk with lantern slides. Mr. Harry Kelley, public relations director, explained in part the proposed campaign against socialized medicine. It was decided to have a called meeting of the society August 5.

August 5, 1949

(Reported by H. L. Wilder, Secretary)

At a called meeting August 5 of Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson Counties Medical Society, Mr. Phillip Overton and Mr. W. E. Syers, both of Austin, representatives of the State Medical Association, reported on recent developments in the fight against socialized medicine. E. A. Rowley, Amarillo, a trustee of the State Medical Association, outlined the duties of doctors in the campaign.

August 16, 1949

(Reported by H. L. Wilder, Secretary)

Cancer of the Skin (slides)—R. P. O'Bannon, Fort Worth.

The regular meeting of Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson Counties Medical Society was held in Pampa on August 16. R. P. O'Bannon, Fort Worth, was the guest speaker.

The society decided to prorate its dues so that doctors who join late in the year need not pay full dues. Plans were made to cooperate with Pampa drug stores in having recordings for radio programs against socialized medicine made and broadcast.

Johnson County Society

June 21, 1949

Glenn R. Wright, John G. Little, Con Hamilton, Jr., R. W. Kimbro, and Tolbert F. Yater, all of Cleburne, spoke at the June 21 meeting of Johnson County Medical Society. A sound technicolor film was also presented at the regular meeting held in Cleburne.

Lubbock-Crosby Counties Society

July 5, 1949

(Reported by M. D. Watkins, Secretary)

Early Diagnosis of Cancer (motion picture).

Members of Lubbock-Crosby Counties Medical Society had a dinner meeting July 5 at J. A. Chatman's hospital, Lubbock, at which thirty-one members and guests were present.

It was voted that the secretary write the state and county tuberculosis associations assuring them of the society's approval of a mass roentgen-ray survey of Lubbock and Texas Technological College, since it was not feasible for the mobile unit to come to Lubbock to examine only the college students.

A model constitution was distributed to members and Clyde Elkins reported on the progress of the Third District Medical Society meeting, which is to be held in Hotel Lubbock this fall.

The motion picture named above was shown.

August 2, 1949

(Reported by M. D. Watkins, Secretary)

The National Political Picture for Socialized Medicine—Mr. Ed Syers, Austin.

Twenty-seven members and guests were present at the August 2 meeting of Lubbock-Crosby Counties Medical Society in Lubbock.

Loyd A. Storrs was elected to membership upon application. Clarence S. Mast reported on the Red Cross blood bank. Mr. Syers' talk on the above subject was centered around four points: (1) the Minimum Standards law recently passed in Texas; (2) the political aspect of the national medical situation; (3) the status of the socialized medicine campaign; and (4) long-range recommendations for the medical association. His talk was followed by a question and answer period.

Pecos-Jeff Davis-Presidio-Brewster Counties Society

August 2, 1949

(Reported by W. E. Lockhart, Secretary)

Present-Day Summation of Developments in Syphilology—J. C. Kern, Sanderson.
Novocain in Obstetrics (motion picture)—Courtesy of Winthrop-Stearns Co.

Pecos-Jeff Davis-Presidio-Brewster Counties Medical Society met August 2 at Sul Ross College, Alpine. Eight members and four guests were present.

Ben A. McReynolds was accepted as a transfer from Ector-Midland-Martin-Howard-Andrews-Glasscock Counties Medical Society. Dr. Kern's talk on the above subject included an evaluation of diagnostic blood tests, the clinical course of the untreated disease, and recent trends in treating syphilis by penicillin alone.

Stephens-Shackelford-Throckmorton Counties Society

July 30, 1949

Fever of Undetermined Origin—H. B. Griffin, Fort Worth.
Peritonitis of Appendiceal Origin—R. D. Bickel, Fort Worth.
Management of Acute Laryngitis and Bronchitis—E. S. Cunningham, Jr., Fort Worth.

The Stephens-Shackelford-Throckmorton Counties Medical Society met at W. B. Guinn's home on Possum Kingdom Lake, July 30. The program outlined above was given, and special entertainment included boat rides on the lake.

AUXILIARY SECTION

LEGISLATIVE CHAIRMAN REQUESTS MEETING DATES

The proponents of socialized medicine are marshalling their forces for an all-out drive during the coming Congressional elections, and Mrs. A. B. Pumphrey, Fort Worth, legislative chairman for the Woman's Auxiliary to the State Medical Association of Texas, has requested the cooperation of Auxiliary members throughout the state in obtaining information needed by the American Medical Association in its educational campaign: the time and place of meetings of all types of representative organizations, local, state, and national.

"Medicine's campaign," the directors of the campaign point out, "thus far has proved that the majority of Americans who know the facts are opposed to Compulsory Health Insurance. In the months ahead, it is our job to translate that opposition into formal resolutions—concrete evidence of the people's conviction. We must get representative organizations of every type and nature on record, stating their members' position. Since most programs are arranged 30 to 60 days in advance of meeting dates, now is the time to begin laying the groundwork for favorable action from groups meeting during the autumn months. . . . the Woman's Auxiliaries in some states are giving excellent help to their societies in this work and should, of course, be active in all areas."

Mrs. Pumphrey asks that members of county auxiliaries contact the presidents of local organizations and report to her any important general meetings which are scheduled for the coming months. Her address is Route 8, Box 107, Fort Worth.

ANNUAL REPORTS OF COUNTY AUXILIARIES

(EDITOR'S NOTE: This is a continuation from page 611, August, 1949, issue of the JOURNAL of the annual reports presented by county auxiliaries at the annual session of the Woman's Auxiliary to the State Medical Association of Texas in San Antonio, May 2-5, 1949.)

Nacogdoches County

The Nacogdoches County Medical Auxiliary meets in regular session the second Wednesday of each month. We have 16 active and 2 honorary members, including 2 new members.

This year our main project was a silver benefit tea, the proceeds to go to CARE for needy families in Europe. One hundred fifty dollars was realized from this tea, taking care of fifteen packages to be sent abroad.

Our annual Christmas party was in December. Small gifts were exchanged, and it was voted to give a Christmas basket to some needy family in the county.

Our auxiliary took an active part in collecting material and writing to our Representative and Senator on passage of the Minimum Standards Bill.

In February, Mrs. Samuel M. Hill, Dallas, was our guest. On this occasion, several Lufkin ladies met with us. Mrs. Hill talked on the work and aims of the Auxiliary.

Besides State and National dues, donations were made to the Student Loan Fund and the Memorial Fund.

We observed Doctor's Day on May 1.

MRS. C. F. NEUVILLE, Nacogdoches.

Orange County

The Woman's Auxiliary to the Orange County Medical Society consists of 11 paid members, 3 paid members-at-large, and 5 honorary members. Our average attendance is about 12.

The meetings are held on the first Tuesday of each month. They are so arranged that the business, social, and study phases are adequately met. We held ten meetings this year including Doctor's Day, which was observed February 17 with a chicken barbecue. There have been seven health talks and two programs on public relations. Each meeting has been reported in the local paper and also sent in to the STATE JOURNAL.

Eight prospective nurses have been contacted and several talks were made on nurses' training. Sixty hours were given to teaching Red Cross nursing. One nurse has been recruited for training.

Fifteen doctors, 15 doctors' wives, 17 children, and 5 servants were given physical examinations.

The auxiliary bought rugs for the Old Folks Home; sent food to Girls Haven; gave to the Memorial Fund, Student Loan Fund, and Library Fund; and placed *Hygeia* subscriptions in all public schools over the county.

Officers for 1949 have been president, Mrs. C. B. Shaddock; vice-president, Mrs. O. C. Seastrunk; and secretary-treasurer, Mrs. C. M. Covington.

Officers-elect include president, Mrs. G. Y. Swickard;

Officers of the Woman's Auxiliary to the State Medical Association of Texas: President, Mrs. Joseph B. Foster, Houston; President-Elect, Mrs. William M. Gambrell, Austin; First Vice-President (Organization), Mrs. Paul Brindley, Galveston; Second Vice-President (Physical Examination), Mrs. Howard E. Puckett, Amarillo; Third Vice-President (Hygeia), Mrs. P. M. Kuykendall, Ranger; Fourth Vice-Presidents (Program), Mrs. L. S. Thompson, Dallas; Corresponding Secretary, Mrs. Mark H. Latimer, Houston; Recording Secretary, Mrs. R. Ernest Clark, Memphis; Treasurer; Mrs. V. M. Longmire, Temple; Publicity Secretary, Mrs. R. T. Wilson, Austin; Parliamentarian, Mrs. Fred Sutton, Beaumont.

vice-president, Mrs. C. M. Covington; and secretary-treasurer, Mrs. M. E. White.

MRS. C. B. SHADDOCK, Orange.

Potter County

The Woman's Auxiliary to Potter County Medical Society held eight interesting and informative meetings during 1948. Attendance at our luncheon meetings has been outstanding. Our program has been educational. The various programs have consisted of informative talks and discussions on national and state legislation concerning health.

In March the following officers were elected: president, Mrs. R. R. Swindell; first vice-president, Mrs. Ralph Carroll; second vice-president, Mrs. William Klingensmith; treasurer, Mrs. Brad Crumley; secretary, Mrs. Merrill Winsett; and parliamentarian, Mrs. E. A. Rowley.

The Third District meeting was held in Amarillo. The auxiliary entertained visiting wives with a luncheon before the business meeting.

MRS. R. R. SWINDELL, Amarillo.

Rusk-Panola Counties

The Rusk-Panola Counties Auxiliary was organized November 23, 1948, with 26 women present. Our State President, Mrs. Samuel M. Hill, Dallas, and our council woman, Mrs. Paul Stokes, Crockett, were with us for this organization.

There are 27 doctors' wives in our two counties and we have 24 paid memberships to date.

We meet monthly for a joint dinner with the doctors, then have our separate business meetings. We observed Doctors' Day on March 15 with a dinner, then had a guest speaker and an original musical skit which was in the form of a "take-off" on the men and was written and presented by five local nurses.

For the three meetings held this year, we have had joint programs with the doctors, but we do not plan to do this all the time and would welcome program suggestions.

On April 15 we will be hosts for the Eleventh District meeting and have planned a joint luncheon at noon, then will have a tea for visiting ladies, dentists' wives, and widows of local doctors.

We have an enthusiastic group with excellent attendance and cooperation.

MRS. J. C. ALLEN, Henderson.

Smith County

The Auxiliary to the Smith County Medical Society has had a successful and pleasurable year's work. Our project has been to raise about $500 to furnish a room in the new hospital in Tyler. Part of this amount has already been raised by giving a rummage sale. The remainder is to be acquired by sponsoring a style show this summer.

For the first time in many years we have printed a yearbook and had eight regular monthly meetings. The theme for the year's programs was "Public Relations of the Medical Profession." Four programs on this subject were as follows: "Public Relations and Its Aims," "The Doctor's Wife and Her Responsibility to the Community," "The Doctor and His Professional Philosophy," and "*Hygeia* and Its Mission." Other meetings for the year were as follows: one business meeting; one Doctor's Day dinner with a fine arts program and an address by a minister; one all day meeting in which we assisted the district council woman in her meeting and entertained the State President and the district members at a luncheon and a tea, the State President giving an address at the tea; and one open meeting with a doctor speaking on "Cancer."

In various programs through the year we included in our study the American Medical Association Code of Ethics, the twelve point plan of the A.M.A., the organization of the A.M.A., the Minimum Standards Bill, and voluntary prepayment plans for medical care.

We gave four health talks and two talks on legislative problems. We sent telegrams to our legislators favoring the Minimum Standards Bill. One of our members gave two talks on nurse recruitment to P.T.A. assemblies, and one talk to about two hundred high school girl graduates.

Our membership consisted of 42 in all, with 3 of those being new members and 2 members-at-large. Sixteen husbands, 35 members, 61 children, and 12 servants reported physical examinations. Eighteen took *Hygeia* subscriptions; 5 were given as gifts; 3 members subscribed to the *Bulletin*, and 1 copy was placed in a school. One hundred thirty-three clippings were sent to the State Medical Association at Austin.

Our publicity chairman sent eight reports to the STATE JOURNAL and ten to our local paper. Our yearbook was sent to the State Medical Association and to the State Historian. One of our members assisted in organizing a new auxiliary in Henderson. The president attended the State Board meeting and the state convention.

We made contributions as follows: George Plunkett Red Fund $5, Student Loan Fund $7, Memorial Fund $5, and American Red Cross $5.

MRS. W. HOWARD BRYANT, Tyler.

Tarrant County

The Woman's Auxiliary to the Tarrant County Medical Society has had seven regular meetings to date. This Auxiliary has 253 members, 16 of whom are new this year, and there are several more planning to join now. We have 8 members-at-large.

A study group among our own members was organized to study socialized medicine. Senate Bill 5 was studied and discussed, as were also authoritative articles from various sources. The leader of this group furnished material on the subject for a school debate. Several talks on socialized medicine were either given or sponsored by auxiliary members for club groups.

The Program Committee planned a versatile program for the year. The program included health, public relations, interior decoration, book review, music, style show, and a talk by the State President.

One meeting was designated as Public Health Day. One of our local doctors talked on "Recent Trends in Psychiatry."

The public relations meeting was open to guests. Approximately 300 people attended. Dr. George A. Schenewerk of Dallas talked on socialized medicine.

The Public Health Committee reported 378 physical examinations. This committee also assisted, with the Public Relations Committee, in the annual American Heart Association drive by placing more than 600 plastic hearts in the business districts of Fort Worth.

Through the Nurses' Aid Committee, the auxiliary helped financially several preclinical and graduating nurses. This committee also assisted the hospitals in the annual nurse recruitment program.

The Social Service Committee placed Christmas baskets of food and clothing with a needy family. Through this committee, the auxiliary donated to the Red Cross, Good Fellows, and Santa Pal Charity funds.

The Legislative Committee kept the auxiliary posted on the important legislative news. Many of our members attended the Senate and House of Representative meetings in Austin to help push the Minimum Standards Bill. Many members have written letters to senators, representatives, and congressmen.

The Memorial Fund Committee has been responsible for providing amply the necessary clothing and other needs of elderly members who need our help.

The Hygeia Committee pushed the sale of that magazine.

Some of the members have donated individual time and service to the Red Cross, Cancer Society, P.T.A., Y.W.C.A., Community Chest, Scouts, Camp Fire Girls, Federated Clubs, hospital auxiliaries, poll tax sales, and so forth.

There have been reports and notices of meetings sent regularly to the local newspapers and many to the STATE JOURNAL.

For our social contact with each other, we have had either a luncheon or tea at each meeting. Our one big party for our husbands was a joint party with the Dental Auxiliary and their husbands. It was a gala costume affair, called the "Fort Worth Frontier Fandangle." The decorations, costumes, and program were in keeping with the Fort Worth Centennial, which is being celebrated this year. Also social contact with each other has been stimulated by the square dance class-club which has met every other Saturday night. The Social Committee is planning one other party for the year. It probably will be a barbecue or picnic at the lake.

Mrs. Samuel M. Hill, State President, talked to us in November. She passed on information that she had received from the Chicago meeting, and told us of the plans of the year for the State Auxiliary.

The last meeting for this fiscal year will be a tea on May 13. The main business will be the installation of officers.

MRS. J. FRANKLIN CAMPBELL, Fort Worth.

Taylor-Jones Counties

The Woman's Auxiliary to the Taylor-Jones Counties Medical Society consists of 48 members. Monthly programs were given, and we endeavored to carry out the program as outlined by the State Auxiliary.

We had the privilege and pleasure of having our State President, Mrs. Samuel M. Hill, with us at our November meeting. She offered many helpful suggestions.

Health education was stressed and we are happy to report a total of 94 physical examinations. Health talks were given in all of the schools by our doctors. A health education program was given for the City Federation and one for the auxiliary.

Doctor's Day was observed in December, with a dinner at which 120 doctors and their wives were present.

Fourteen of our members subscribed to *Hygeia* and the auxiliary subscribed to the *Bulletin*. The majority of our members are readers of *The Journal of the American Medical Association* and the STATE JOURNAL.

Through the efforts of the auxiliary members $2,264.50 was collected for the Community Chest and $137 for the Red Cross. Our members have all been active in health projects such as cancer, tuberculosis, heart, and infantile paralysis. Our auxiliary made the following donations: $5 to the State Library Fund, $5 to the State Memorial Fund, $5 to the Student Loan Fund, $5 to the George Plunkett Red Student Loan Fund, $5 to the Sunshine Nursery, and $5 to the Red Cross.

Notices of the auxiliary activities were sent for two issues of the STATE JOURNAL and seven notices have been sent to the local paper.

Our membership is on the alert regarding legislation. In study groups and clubs, members try whenever possible to present any pending or proposed legislation.

The auxiliary placed nurse recruitment posters and 249 bulletins on nursing education in high schools in four towns. Our project for the year was the sponsoring of a series of parties for the student nurses. Six parties were given for these girls, including a barbecue, book review, Halloween party, skating party, picnic, and a book shower. Pictures were taken by the press of one of these parties and later pictures were made of the nurses at work; these were published in a series of newspaper articles about the student nurses.

We are sending an exhibit to the state meeting and our president-elect plans to attend the School of Instruction.

MRS. JAMES P. BRIDGES, Abilene.

Tom Green-Eight County

A well rounded, interesting program and an active, participating membership have enabled the Tom Green Eight-County Medical Auxiliary to carry out its two main objectives of the year in a satisfactory manner. These objectives are: (1) to increase enthusiasm and friendliness among the members of the organization and (2) to stress participation in worth-while community projects, particularly those dealing with health.

Attendance at meetings during the year has been excellent. Membership has increased with a net gain of 7 and no resignations. Total membership is now 40. All committees have functioned willingly and well. Judging from the comments heard and the letters of commendation received from community agencies, the auxiliary is recognized as an organization vitally interested in community welfare.

A special project, started this year, is aiding the Child Welfare Agency. Boxes filled with fruit, candy, nuts, toys, and wearing apparel were given to 30 underprivileged children at Christmas. Personal kits, containing articles such as tooth brush, comb, soap, towel, and cuddle toy are being made by auxiliary members and are given to each child who is placed in a foster home. This project will continue to grow in scope and value as time goes on.

Probably the greatest time consuming project in which the organization participated during the year was in connection with the mass tuberculosis x-ray project carried on in Tom Green County from April 16 to 26. The auxiliary president was chairman of the hostess committee. Two auxiliary members, or their substitutes, were on duty at each machine at all times to greet those being x-rayed, to pin tags, and to give out information and literature.

The auxiliary has given active assistance to the following: Cancer Society, Infantile Paralysis Society, Baby Clinic, Planned Parenthood Society, information desk at Texas Tuberculosis Association meeting, City Federation style show, health booth at County Fair, Christmas Seal sale, fun and frolic recreation project, Red Cross drive, and County Memorial Library.

Legislative work consisted in (1) one meeting at which Dr. R. E. Windham, vice-president of the State Medical Association, discussed the Minimum Standards Bill and socialized medicine; (2) contacting our district representatives urging passage of the Minimum Standards Bill; (3) sending auxiliary representatives to the House hearing relative to the Minimum Standards Bill.

Purely social activities were a Christmas luncheon, a coffee to which all local doctors' wives were invited, a book review tea and a musical tea for members and their guests, a party for the medical society in celebration of Doctor's Day, and a picnic for doctors and their wives.

MRS. W. B. BUTNER, San Angelo.

Travis County

Eight regular meetings of Travis County Auxiliary were held in 1948-1949.

In October the year began with a luncheon honoring Mrs. Samuel M. Hill, our State President, who spoke of work for the year.

There were two meetings at which doctors spoke. Dr. John

Dale Weaver showed a film and spoke on "Cancer Control." Dr. L. C. Paggi spoke on "Heart Disease." Officers of civic and welfare clubs were special guests for these meetings. Their genuine appreciation for invitations showed the public interest in these topics as well as for the able presentation by the speakers.

Two style show luncheons were held. In November the members of the staff of the State Medical Association and our own new members were honor guests. In March the officers of the newly organized Williamson County Auxiliary were guests.

In December a Christmas musicale, to which guests were invited, was well done and appreciated.

In February it was necessary to cancel the entertainment planned for the doctors. A book review of "Doc's Wife," by Faye Lewis, was enjoyed both by doctors' wives and by guests.

For the last meeting of the year Miss Willie Birge made an unusual talk on "Flower Arrangement." Guests were invited. New officers were installed for 1949-1950.

Civic and legislative affairs have received much attention. In May, 1948, cards were distributed in the interest of outstanding candidates, national, state, and local. The legislative committee worked hard for the Minimum Standards Act. Letters were written in the name of the auxiliary thanking legislators for their support, and cards were mailed by individual members recognizing the work of legislators.

More than 100 clippings were collected for public relations.

The auxiliary staffed booths for two days for mass chest x-ray examinations. The auxiliary also worked on the telephone committee contacting groups and individuals for this examination. A zone chairman and four members from the auxiliary worked in the Red Cross drive. The auxiliary distributed literature downtown for the cancer campaign. Contributions were made to the State Library Fund, the Student Loan Fund, the wife of one of our own former doctors, the cancer fund, and the Child and Family Service.

The membership at the close of the year was 150.

One hundred high school girls were invited to a talk and for a trip through a local hospital for the purpose of encouraging enrollment for nurses training.

MRS. A. H. NEIGHBORS, Austin.

Washington County

The Woman's Auxiliary to the Washington County Medical Society meets the last Monday in the month. Eight meetings are held each year, and these meetings consist of social activities, business sessions, and programs which are in the form of current medical news, papers on subjects pertaining to the medical profession, and a luncheon preceding each meeting. Installation of new officers is held at the luncheon in May. The auxiliary has a membership of 27 members, including 4 members-at-large. Theme of this year's work was "Health."

The auxiliary sent $5 to the Student Loan Fund and $5 to the George Plunkett Red Student Loan Fund. Twelve *Hygeia* subscriptions were sold, including one gift subscription to Blinn Junior College and one to the Brenham Public Library.

Doctor's Day was observed in October with a barbecue at Dr. C. E. Southern's "Playhouse." Two guests from Houston were speakers on cancer and two cancer films were shown.

During the year one talk on legislative problems and one talk on health were given. Doctors, wives, children, and servants totaling 38 had physical examinations. Three prospects have been contacted for nurse recruitment and one talk was given. Two talks were made to the Girl Scouts. Auxiliary members spent several afternoons rolling bandages for the cancer committee and worked with the tuberculosis mass x-ray project for the county.

MRS. ROBERT A. HASSKARL, Brenham.

Wharton-Jackson-Matagorda-Fort Bend Counties

The Wharton-Jackson-Matagorda-Fort Bend Counties Auxiliary entertained the Auxiliary to the Brazoria County Medical Society at dinner and bridge; instituted a yearly $50 scholarship in pre-nurses training at the Wharton County Junior College; and contributed to the Library Fund, Student Loan Fund, and George Plunkett Red Fund.

MRS. V. A. BLACK, Wharton.

Wichita County

The Woman's Auxiliary to the Wichita County Medical Society was organized as a social group; however, we have one project: indigent tuberculosis and chest patients. We make calls, furnish magazines, and send Christmas boxes.

This year we had the executive secretary of the Tuberculosis Society talk at one meeting, and each member was asked to make a donation of canned food, clothing, or money. We had one program on socialized medicine with Dr. Martha Buchanan as our speaker.

We have a committee appointed to investigate the expense of furnishing a doctors' lounge at the Wichita General Hospital, and if this is accomplished, we plan to keep it in repair from year to year.

MRS. J. A. JOHNSON, Wichita Falls.

AUXILIARY NEWS

Cass-Marion Counties Auxiliary

Cass-Marion Counties Auxiliary met July 13 in Hughes Springs after a dinner with the Medical Society. The auxiliary meeting was held in the home of Mrs. H. L. D. Jenkins. After a short business session at which six members were present, Mrs. Jesse DeWare, III, spoke on public relations.—Mrs. M. J. Brooks, Jr.

Dallas County Auxiliary

Dallas County Auxiliary has formed a Visual Education Committee to further scientific sex education in the public schools of the city. Mrs. Speight Jenkins is chairman and Mrs. Cecil O. Patterson vice-chairman.

The committee chose "Human Growth" and "The Story of Menstruation" as films best suited to the age group it wishes to reach. Both films have been approved by members of the Dallas County Medical Society.

The committee has received from school officials of Highland Park and Dallas County approval of its plan to ask permission of P.T.A. presidents to show the films at their meetings, at the same time announcing that the films will be shown on certain dates at the various schools to boys and girls separately.

Children will be admitted only with the written consent of their parents. After presentation of the films, the children will be invited to ask questions. A "speakers bureau" from the auxiliary, which has been prepared with lectures by two doctors, will explain the films and answer the questions of the children.—Mrs. Speight Jenkins.

Randall-Deaf Smith-Parmer-Castro-Oldham Counties Auxiliary

Members of Randall-Deaf Smith-Parmer-Castro-Oldham Counties Auxiliary met with their husbands for dinner in Hereford on June 1, afterwards adjourning to the home of Dr. L. B. Barnett for the evening.

DEATHS

R. L. PAGE

Dr. Roy Lee Page, Tyler, Texas, died May 7, 1949, at his home of coronary occlusion.

The son of Benjamin Franklin and Mary (Phelps) Page, he was born September 5, 1885, in Smith Grove, Ky. He was educated in the public schools of Smith Grove and Bethel College, Russellville, Ky., and was graduated from the University of Louisville Medical Department in 1909. In 1924 he did postgraduate work in eye, ear, nose, and throat at Tulane University, New Orleans, and the University of Chicago. After his graduation, he came to Texas. Dr. Page practiced in Seagoville until 1916, in Henderson from 1916 to 1924, and in Tyler from 1924 until his death.

DR. ROY L. PAGE

He was one of the founders of Mother Francis Hospital, Tyler, and served on its staff. For twenty years he was a consultant in eye, ear, nose, and throat for the St. Louis Southwestern Railroad Company. He was also a physician and surgeon for the International and Great Northern Railroad Company.

Dr. Page was a member of the American Medical Association, State Medical Association, and the Smith County Medical Society. He was a past president of the Smith County Medical Society and was on many standing and special committees. An active member of the Marvin Methodist Church, he served on the board of stewards for twenty years. He was active in civic affairs, and during the war he was an eye, ear, nose, and throat specialist on the local draft board.

In 1911 Dr. Page married Miss Carrie Beachum, who with one daughter, Mrs. Dorothy Robertson, San Antonio, survives.

T. W. BUFORD

Dr. Talma Wooton Buford, Minter, Texas, died June 2, 1949, in a Paris Sanitarium of arteriosclerosis.

Born May 30, 1874, in Paris, Texas, Dr. Buford was the son of Simmeon and Frances (Cofer) Buford. He was educated in private schools and a business college in Paris and was graduated from the Louisville Medical College, Louisville, Ky., in 1898. Dr. Buford did general practice in the Minter community for fifty-three years.

DR. T. W. BUFORD

A charter member of the Lamar County Medical Society, Dr. Buford was formerly president of the society. He also served at one time as president of the Fourteenth District Medical Society. Dr. Buford was elected an honorary member of the State Medical Association in 1949 and was a member of the American Medical Association. A member of the International Order of Odd Fellows and the Masonic Order, he was also a member of the Baptist Church. Dr. Buford was especially interested in mental hygiene and was given a distinguished service award for his work in that field by the Hogg Foundation in 1948.

On December 27, 1889, in Itasca, Dr. Buford married Miss Georgia Hickman, who survives. Other surviving relatives are his sisters, Mesdames S. A. McCuistain and Prudence Tainter, both of New Boston.

J. B. DRIVER

Dr. John Beasley Driver, Dallas, died July 25, 1949, in a Dallas hospital.

Born March 19, 1897, in Oakwood, Texas, he was a son of the late Dr. J. D. Driver, pioneer physician of Freestone County, and a brother of the late Dr. Sim Driver, Dallas

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

orthopedic surgeon. He received his preliminary education in Iola High School; Texas Christian University, Fort Worth; and Baylor University, Dallas; and received his medical degree from Baylor University College of Medicine, Dallas, in 1926, later doing postgraduate study in New York and San Francisco. After an internship and residency at Parkland Hospital, Dallas, he practiced in Wink for several years. Since 1939 he had practiced in Dallas, specializing in proctology.

Dr. Driver was a member of Dallas County Medical Society, the State Medical Association, American Medical Association, the Texas Society of Gastroenterologists and Proctologists, and the Dallas Proctological Society. He was clinical assistant professor at Baylor College of Medicine from 1938 to 1943, and associate attending physician at Baylor University Hospital. Dr. Driver was attending physician in proctology at Gaston and Parkland Hospitals and a member of the courtesy staffs of Methodist, St. Paul, and Medical Arts Hospitals. A member of Phi Chi fraternity and of the Masonic Order, he belonged to the American Legion and the Dallas Athletic Club.

Surviving relatives are his three sisters, Miss Dayle Driver, Miss Mary Sue Driver, and Mrs. Rosa Driver Derum, all of Dallas.

J. R. DICKSON

Dr. James Rucker Dickson, Arp, Texas, died June 14, 1949 at a Jacksonville hospital of coronary occlusion.

The son of Mack Mahon and Ada (Rucker) Dickson, Dr. Dickson was born November 14, 1889, at Dawson. Educated in the public schools of Dawson, he taught school in Navarro County. He also worked in a drug store and

DR. JAMES R. DICKSON

studied pharmacy, later becoming a registered pharmacist. He attended the University of Texas, Austin, and the Medical Department of Southern Methodist University, Dallas, and was graduated from Baylor University College of Medicine, Dallas, in 1916. He served an internship at Parkland Hospital, Dallas, and was a resident physician at the Texas Pacific Railroad Hospital, Marshall, until World War I, when he served in France with a telegraph batallion with the rank of first lieutenant. He practiced in Dawson from 1919 to 1931, at which time he moved to Arp, where he practiced until his death.

Dr. Dickson served on the staffs of Mother Frances Hospital, Overton Hospital, and Nan Travis Hospital in Jacksonville and was city health officer in Arp. A trustee and former steward of the Arp Methodist Church, he was a thirty-second degree Mason and a member of Dallas Scottish Rite bodies, Hella Temple Shrine, and the Eastern Star. He was also a director in the Rotary Club, post service officer and chaplain for the American Legion, and a member of the Veterans of Foreign Wars.

He married Miss Lois Jones of Mount Calm on May 25, 1924. His wife survives, as do their daughter, Mrs. Bettye Jane Lucas, Houston; his brother, Thomas M. Dickson, Healdton, Okla.; and two sisters, Mrs. Mary McKnight, Dallas, and Mrs. Rachel Wright, Tehuacana.

O. N. HOOKER

Dr. Orval Nathan Hooker, Amarillo, Texas, died in Amarillo on July 5, 1949.

Born in Chicago on January 23, 1916, he received his education at the University of Mississippi, University, Miss., and was graduated from the Tulane University of Louisiana School of Medicine, New Orleans, in 1940. After serving an internship in Duval County Hospital, Jacksonville, Fla., and a residency in Greenville General Hospital, Greenville, S. C., Dr. Hooker was chief surgeon and assistant superintendent of the Mississippi State Charity Hospital, Jackson. He was a captain in the U. S. Army from 1943 to 1946,

DR. ORVAL N. HOOKER

serving two years in the China-Burma region. He was chief resident in obstetrics and gynecology in Aultman Hospital, Canton, Ohio, from July, 1945, to September, 1946, when he moved to Amarillo. He practiced there until his death, specializing in obstetrics and gynecology.

Dr. Hooker was a member of Potter County Medical Society, the State Medical Association, and the American Medical Association. He belonged to the Amarillo Club and was a member of the Christian Church.

In 1940 in New Orleans, Dr. Hooker married Miss Frances Asbury, who survives, along with their young daughter, Frances Ann. Also surviving are his mother, Mrs. G. C. Cortwright, and brother, G. C. Cortwright, Jr., both of Rolling Fork, Miss., and his sisters, Mrs. W. A. Chase, Jamestown, N. D., and Mrs. V. B. Schimmel, Rolling Fork, Miss.

J. B. FOSTER

Dr. Joseph Beverly Foster, Houston, Texas, died June 25, 1949, of coronary thrombosis at his home.

Born in Ennis, January 28, 1895, he was the son of James Everett and Ann (Treadway) Foster. Educated in the Sterling City High School; Abilene Christian College, Abilene; and Austin College, Sherman, he was graduated from the University of Texas School of Medicine, Galveston, in 1920. After serving an internship at St. Joseph's Infirmary, Houston, he became a partner in the Houston Clinic and served on its surgical staff until 1927, when he was admitted to the graduate school of Harvard Medical School, Boston. Here, he had two years of training in orthopedic surgery with appointments in Massachusetts General Hospital and in Children's Hospital, Boston.

Dr. Foster returned to Houston in 1930 to a private practice in orthopedic surgery. Throughout the years he maintained membership in Harris County Medical Society, the State Medical Association, and the Southern and American Medical Associations. A charter member and early president of the Texas Orthopedic Association, he was a member

DR. JOSEPH B. FOSTER

of the Texas Surgical Society and a charter member of the Houston Surgical Society. Dr. Foster was also a member of the American Academy of Orthopedic Surgeons and a diplomate of the American Board of Orthopedic Surgery, for several years serving as an examiner on the Board.

Dr. Foster was particularly interested in working with crippled children. He was chief surgeon of the Arabia Temple Crippled Children's Clinic, chairman of the Medical Advisory Committee for the Harris County Chapter of the National Foundation for Infantile Paralysis, member of the advisory committee of the Texas Society for Crippled Children, and member of the advisory committee of the Crippled Children's Division of the State Department of Health since its origin a number of years ago.

He was professor of orthopedic surgery and chairman of the Department of Orthopedics in Baylor University College of Medicine and orthopedic consultant at the M. D. Anderson Hospital for Cancer Research, Houston, and for the U. S. Veterans Hospital, Houston. Recently he was appointed consultant in orthopedic surgery at Brooke General Hospital, Fort Sam Houston, San Antonio, and regional orthopedic consultant of the U. S. Veterans Administration.

Dr. Foster was an active member of the staffs of St. Joseph's Infirmary and Memorial, Methodist, and Hermann Hospitals, serving as president of the staffs of St. Joseph's Infirmary and Methodist Hospital. At the time of his death he was chief of the orthopedic service of St. Joseph's Infirmary.

A member of Phi Beta Pi fraternity, Scottish Rite bodies, and Arabia Temple Shrine, he served on the board of the Ripley Foundation Center and for two years on the Houston Board of Health. Dr. Foster for many years served as an elder in the Central Church of Christ.

Dr. Foster married Miss Lucile Parrish of Sherman, who survives him. Other surviving relatives are his parents, Mr. and Mrs. J. E. Foster, Miles, Texas.

M. B. MURDOCK

Dr. Marion Bailey Murdock, Eastland, Texas, was killed in an airplane crash near Meridian, Miss., on June 12, 1949, which also took the life of his wife, the former Katherine Clay Mallory. The couple were returning in their private plane from the American Medical Association convention held in Atlantic City.

DR. MARION B. MURDOCK

The son of Dr. and Mrs. Marion Theodore Murdock, Dr. Murdock was born in Russell County, Va., on July 15, 1917. He received his preliminary education in John Marshall High School and Richmond College, Richmond, Va., and received his medical degree from the Medical College of Virginia, Richmond, in 1943. After an internship at Blodgett Memorial Hospital, Grand Rapids, Mich., he served

a two-year residency in surgery at Duke University Hospital, Durham, N. C., and was an assistant instructor in pathology at Duke University School of Medicine. He then moved to Eastland, Texas, where he practiced until his death.

Dr. Murdock was a member of Eastland-Callahan Counties Medical Society, the State Medical Association, and American Medical Association. He had been a member of the Issaquena-Sharkey-Warren Counties Medical Society in Mississippi. A member of the Academy of General Practice, he belonged to Phi Chi fraternity and Lions Club. He was a member of the Presbyterian Church.

Dr. and Mrs. Murdock were married in Richmond, Va., on December 21, 1943.

H. J. GONDOLF

Dr. Harold J. Gondolf, Austin, Texas, died June 3, 1949, in his office of coronary occlusion.

Born June 20, 1890, in New Orleans, Dr. Gondolf was the son of Victor and Cecelia (Nestor) Gondolf. He entered Tulane University, New Orleans, in 1907 and in 1913 was graduated from the Tulane Medical School. His internship and residency were served in Charity Hospital, New Orleans, after which he entered private practice in that city.

Dr. Gondolf volunteered for service soon after the United States entered World War I and was commissioned a first lieutenant at New Orleans on June 1, 1917. He served with

DR. HAROLD J. GONDOLF

the 332nd Infantry from Cleveland, Ohio. During his tour of duty, he was attached to the Fourth and Sixth Italian Armies at Base Hospital 102 in Vicenza, Italy. He was discharged May 2, 1919, after which he served four years in Central America with the U. S. Public Health Service.

Dr. Gondolf was assistant pathologist at Charity Hospital, New Orleans, from 1924 until 1926, and was pathologist there from 1926 until 1928, doing extensive study and work under Dr. Rudolph Matas. In 1930 he went to the University of Mississippi School of Medicine, Oxford, Miss., as assistant professor of pathology and bacteriology and taught there until he came to Austin in 1938. From then until his death Dr. Gondolf operated the Gondolf Clinical and Pathological Laboratory. He was a member of the State Medical Association and the American Medical Association.

Dr. Gondolf was married April 12, 1917, to Mrs. Leah Knobloch Moore of New Orleans, who died July 17, 1944. In 1947, the doctor married Mrs. Lelia DuBose Phillips of Corsicana and Gladewater, then a medical technologist at Brackenridge Hospital, Austin.

Dr. Gondolf is survived by his wife; one son, John F. Gondolf, Dallas; a daughter, Mrs. Shirley Maroney, New Orleans; two stepsons, Gus and Thomas Moore, New Orleans; one sister, Mrs. George Sassinot, Tampa, Fla.; and four grandchildren.

F. I. REID

Dr. Franklin Isaac Reid, formerly of Dumas, Texas, died in Long Beach, Calif., on May 9, 1949, of cancer of the pancreas.

Born October 4, 1900, in Blair, Okla., he was the son of Mr. and Mrs. W. A. Reid. He received his preliminary education in Blair High School and earned his bachelor of science degree at the University of Oklahoma, Norman, Okla., in 1924. Dr. Reid was graduated from the University of Oklahoma School of Medicine, Oklahoma City, in 1927. He served an internship at Covington, Ky., and Memphis General Hospital, Memphis, Tenn. He recently took a refresher course in general surgery at Los Angeles County Hospital, Los Angeles.

Dr. Reid practiced in Altus, Okla., Pampa, White Deer, and Dumas, having practiced from 1937 until 1946 in

DR. F. I. REID

Dumas. He was a member of Dallam-Hartley-Sherman-Moore Counties Medical Society, of which he was secretary in 1945. He belonged to the State Medical Association and the American Medical Association and was formerly Moore County health officer. A member of Phi Chi medical fraternity and the Lions Club, he was a deacon in the First Baptist Church and a Mason.

Dr. Reid was married on May 29, 1929, at Hernando, Miss., to Miss Daulcy J. Kentha Newman, who survives. Other surviving relatives are his children, Patsy Anne, Jim Frank, and Phillip Newman; his mother, Mrs. W. A. Reid; brothers, Dr. John R. Reid, Altus, Okla.; Lewis Reid, Oklahoma City; and sister, Mrs. Candace Appleby, Odessa.